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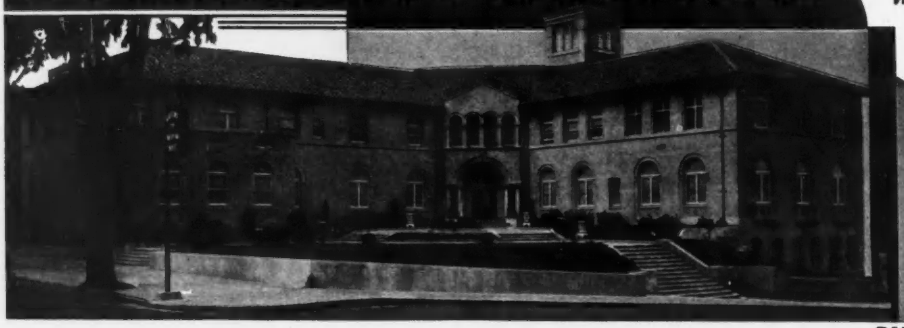

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VOL. 42 JUNE, 1935 No. 6

ORGANIZED MEDICINE IN CALIFORNIA—SOME OF ITS PROBLEMS*

ADDRESS OF THE RETIRING PRESIDENT

By CLARENCE G. TOLAND, M.D.
Los Angeles

AS I stand before this assembly of representative physicians of California, the past year comes to me in retrospect, and the words of the Angel seem particularly appropriate, as when he said to St. John, "These are they which came up out of great tribulation."

OUR PROBLEMS ARE OLD PROBLEMS

We have faced, and are now facing, serious medical-social problems. These problems, however, that have come to our attention so suddenly are not in reality new, but have been gathering these many years. They are not, in general, peculiar to the medical profession, but are aspects of a massive social and economic movement which has grown to such dimensions that it can no longer escape our notice. As they apply to medicine they have not arisen because of any lack of public confidence in the ability of the medical profession.

The standards for entrance to medicine are the highest of any profession. They have repeatedly been raised to obtain men of the highest type in character and technical training, and we can be assured that in the future our places shall be filled with men of distinction.

We can inspect the medical roster of the past with complaisance. The physicians who have willingly offered their lives on the altar of unselfish and self-sacrificing service in the study of disease are legion. We are not boastful. We reverence those names and venerate the heritage they have left to us. We are proud of this tradition of service, and we resent any imputation of dereliction in our duty to the sick.

REPORT OF THE COMMITTEE ON THE COSTS OF MEDICAL CARE

The report of the Committee on the Costs of Medical Care, after its five years of study, has been considered by sociologists as a challenge to the medical profession; as an indictment of the present social organization for the care of the sick.

In reality, a detailed study of this report is not at all discouraging. When we consider that the 9.8 per cent of our people who, according to the report, receive no medical care, include all of those with disorders which, "wholly or in part disable an individual for one or more days," we realize then the minor nature of such illness. Thirty per cent of these were minor respiratory diseases. Hardly anyone consults a doctor for a cold, a sick headache or an attack of so-called lumbago.

The survey made in the State of California during the past year requires more careful scrutiny. Apparent inadequacy of medical care of the indigent for disabling illness was found in 20 per cent. Here, too, the definition of disabling sickness as any disorder interrupting the normal routine of life, would include a high percentage of colds, for which most people consult no physician.

MORBIDITY AND MORTALITY RATES IN THE UNITED STATES

One quite definite criterion as to the adequacy of medical care is the mortality and morbidity rates. Statistics of the League of Nations show that the United States had a lower general death rate, a lower infant death rate, and lower mortality and morbidity rates from diphtheria and tuberculosis in 1933 than any other first-class power for which data are available.

Mortality and morbidity rates have not increased during the depression; they have actually been lower. A study of economic crises for the last one hundred years shows that the total mortality figures, and the morbidity figures for tuberculosis, were definitely lower during the periods of depression than during periods of prosperity. These figures do not find their way into the speeches of the opponents of the medical profession who talk with pathos of the hundreds of thousands of cases of sickness needing medical attention during the past six years.

The health of the North American people is superior to that of any other country in the world, because the quality of medical service is better. The selection of Doctors Whipple, Minot, and Murphy as winners of the Nobel prize for the past year was a tribute not alone to the individual

* Address given at the sixty-fourth annual session of the California Medical Association, Yosemite National Park, May 13, 1935.

ability of the distinguished recipients, it was also a recognition of the excellence of American medicine.

RELATION OF THE WORLD'S ECONOMIC STRESS TO MODERN-DAY MEDICAL ECONOMIC PROBLEMS

The economic crisis has brought in its wake the present medical crisis. Lower incomes do not make medical care more costly, although it may seem relatively more costly. Lowered incomes make it more difficult to pay for medical care, but do not influence the actual costs.

It is an interesting commentary on the American sense of relative values that even during this depression more money is being spent on movies, cosmetics, and tobacco than is spent on medical care. The latter item includes such an extensive list as cost of physician, hospital, drugs (both useful and of the patent medicine type), that which is spent on practitioners other than physicians and surgeons, nursing costs, and the costs of dental service. Twice as much is spent on candy as on hospitals.

We are thus faced with a paradoxical situation in which the nation is able to meet the cost of luxuries, but not of necessities. We are apparently confronted by a dilemma of collective national improvidence rather than actual need. We say national, because individually we meet the many exceptions. Individually, the physician has always considered the sick as his responsibility, their care his life work.

The medical profession has never been indifferent to the welfare of the low-income classes. A very conservative estimate places the value of services donated by physicians of the United States to the care of the indigent and low-income groups, during the last few years, at about one million dollars a day; and almost without exception those institutions offering gratuitous services to these groups depend for their very existence upon freely given services of physicians.

THE RECORD OF THE MEDICAL PROFESSION

When we begin our attempt, therefore, at a solution of the problem of medical care, we may do so with no qualms of doubt as to whether we have properly performed our duties as the natural guardians of health. The abrupt crystallization of the whole problem is the result of the general depression, and nowhere is the consciousness of the existence of the problem more acute than in our own profession.

You are all well aware that from time to time critics, almost invariably laymen, have complained that the medical profession was too slow and backward in adopting new remedies and methods. These critics have complained that physicians were unwilling to take advantage of what appeared (to such critics) to be wonderful medical discoveries. But every one of you realize that, had the attitude of the profession been different, we would now be using a thousand specific cures for certain incurable diseases, all of which would have no effect, except to raise the patient's hopes and lower his financial reserve.

For centuries physicians have adhered to Saint Paul's aphorism, "Prove all things; hold fast to that which is good." This conservatism, this reluctance to apply, perhaps prematurely, apparent medical discoveries before their value has been thoroughly assayed, is often misunderstood by the public.

IS THE CRITICISM FROM LAY SOURCES JUSTIFIED?

Is it not possible, too, that our slowness to accept the various forms of social medicine which have been proposed from time to time—largely by people who know nothing whatever of medicine, and in the main smelling strongly of book-lined studies and the easy chair—arises from the same caution, the same unwillingness to experiment at the expense of the public, that characterized our unwillingness to accept Mr. Wilshire's magic "horse collar" as the answer to all therapeutic problems?

We are probably to blame for many medical misconceptions in the layman's mind. In the past he has been trained to feel that the best care can be obtained only from specialists. The employment of special procedures and special laboratory tests has educated him to feel that failure to employ such methods indicates inferior care. The plight of the general practitioner, until the last few years, has been an unenviable one.

MAJOR AND MINOR ILLNESSES

Eighty-five per cent of the conditions for which most patients consult doctors can be diagnosed and treated by a good general practitioner with only the amount of equipment he carries in his bag. In only 15 per cent are special tests needed. Any failure to provide 85 per cent of the sick with unneeded tests does not constitute inadequate medical care. We must, then, emphasize to the public mind the minor nature of this 85 per cent of the sickness.

The remaining 15 per cent of those sick form the group bearing the greatest medical cost, paying half of the money spent yearly for medical care.

This is the group which requires hospitalization, and suffers from the cost of sudden, unexpected sickness.

THE PRESENT-DAY SOCIAL UNREST

The present culmination of unrest is the result of certain basic social changes of the last several decades. There has been a trend of population to the cities, with a concomitant migration of physicians. There has been a marked drop in the rate of increase of the population. It is estimated that in a generation we shall have a stable population. The period of expansion in this country is apparently reaching its end.

HAS THE UNITED STATES MORE PHYSICIANS THAN IT NEEDS?

At the same time the number of physicians graduated yearly has increased steadily. In a period of accelerated population increase and of expansion, this increase could have been assimi-

lated. But present conditions forbid this; and this steady accretion can only serve to render more difficult a solution of the medical economic problem, already aggravated by the fact that the United States has twice as many physicians per unit of population as any of the leading countries of Europe.

Only last year, Dr. Walter L. Bierring, president of the American Medical Association, emphasized the importance of decreasing this plethora of physicians. In the past this was accomplished by raising the standards for entrance to medical schools; but even this requirement at present is inadequate.

CALIFORNIA'S MEDICAL ECONOMIC SURVEY

In California we have taken a step which may affect the status of every physician. For the first time in this country, representatives of the medical profession have conferred with a committee of the state legislature for the purpose of presenting a tentative plan for the care of the sick.

The action of the California Medical Association in suggesting legislation designed to spread the cost of medical care occurred only after long and earnest consideration.

Twenty-three hundred years ago a great physician pronounced a dictum which has lived through the ages as a guide for the doctor of medicine: "I will follow the system or regimen which, according to my ability and judgment, I consider for the benefit of my patients. With purity and with holiness I will pass my life and practice my art." This spirit that has guided us through the centuries has not vanished, and I am firm in my conviction that there never has been a time other than the present when the medical profession has adhered more rigidly to that oath.

MERITS AND DEFECTS OF INSURANCE PLANS

Our chief concern, as doctors, has been whether a plan for health insurance would or would not be for the benefit of the patient. Although the majority of the House of Delegates, at the special session held in Los Angeles on March 2 and 3, 1935, supported the plan for health insurance, that support fell far short of unanimity. Many are not convinced that such legislation will prove the best for the ultimate welfare of individual patients or the people in general. Such plans in other countries have failed in many particulars to provide satisfactory individual care.

Many also are not convinced that the science of medicine will flourish under a system of regimentation, and believe that the future health of any nation will always depend upon the scientific knowledge of the profession. Such knowledge is predicated upon a freedom of individual research, which may suffer badly under a regimen of mass medicine. It may or may not be significant that the outstanding medical discoveries of the last twenty years have come from our country, and not from any country under a system of general health insurance.

We all are convinced that the medical profession alone is qualified to lead in the development of any plans for an organized system of medical service.

This is an immutable principle to which each physician thinking of his patient's welfare is committed. It has been written by the physician into every consideration of any plan for the care of the sick. It is a fundamental safeguard to protect the patient from political exploitation. It must be the building-stone for any projected plan of medical care. Without it the relation of confident patient to conscientious doctor is destroyed, and the structure of ethical medicine will totter. We hold, as physicians, that the medical profession is the only body qualified, by training, to determine how medicine shall be practiced. No layman has ever been endowed with clairvoyant powers which enable him to differentiate an emergency such as a ruptured ulcer from a benign stomach ache. Nor can we trust such lay ability in a larger measure to manage the technical phases of medicine which require similar training and knowledge to administer.

In conferring with the legislature we have shown a spirit of willing coöperation. May we not hope that the response of the people, through the legislature, will be to respect the judgment of the medical profession, and to grant them the untrammelled leadership in any plan for medical service?

Any infringement of that fundamental principle will be met by the spirited resistance of the medical profession fighting, as always, to protect what we know are essential safeguards for the health of the people.

PHYSICIANS SHOULD BE INTERESTED IN CIVIL POLITICS

If the people demand such legislation, we shall not oppose nor hold aloof from it, but shall lead them in an attempt at an intelligent solution. The only possible solution, however, is by controlled experimentation, by trial and error. The next generation will be occupied with the problems of any plan to be adopted. We, as physicians, must coöperate as never before in a vigilant and stalwart defense against political interference, that the interests of the patient, and the rights and necessities of the sick, be not infringed upon.

During the past year the necessity of such a defense presented itself, and the inherent tendency of physicians to political disinterestedness underwent a change.

When a champion was needed to protect the welfare of the public, out of the ranks of physicians, dentists, nurses, and laymen was organized an independent group which led to the defeat of proposed vicious legislation; and as a direct result of this medical crisis there has been welded a unity of spirit, an *esprit de corps* which must carry us on to other achievements in the future as champions of public health.

THE COMPONENT COUNTY MEDICAL SOCIETIES OF THE CALIFORNIA MEDICAL ASSOCIATION

One of the privileges of the president of this Association, as well as one of his duties, is to visit

the component county societies; and in the fulfillment of this duty I was inspired by the unity and the harmony in which the members of our profession are working. A politician once said: "Only once in every thirty years does the medical profession become sufficiently aroused to become a serious political factor; but when it does, it organizes and operates most effectively." The history of the past year of the profession in this State would seem to prove that he was right. Medical self-esteem has risen and harmony has been promoted, and we have been stimulated to repay, with even greater service, the confidence expressed by the people.

IN CONCLUSION

As we grow older, most of us become conservative, and some of us become reactionary. We must not let our natural conservatism blind us to the fact that we are living in an era of social and economic change, and that, as Grover Cleveland once said, "These are not theories that confront us; they are conditions." In the reasonable consideration of such problems as are confronting us today, it is most important to remember that change is not in itself bad, and that the fact that a thing is new is not a sound reason for its condemnation.

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1930 Wilshire Boulevard.

RESEARCH IN MEDICINE: PRACTICAL APPLICATIONS*

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AND
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WE who are practicing medicine in this enlightened age at times are prone to look upon the methods employed by our predecessors in the profession with an attitude tinged with condescension. We often fail to realize the darkness through which they traveled, and the wonders which they accomplished with the few means at their disposal. The physician of ancient times, hindered in his progress by superstition and religious intolerance, and lacking the principles of the basic sciences from which so much of our knowledge has been derived, would look with awe upon the methods of diagnosis at our command, the vast array of conditions remediable by surgical intervention, and even the therapeutic equipment contained in the ordinary emergency bag of the present-day practitioner. It is the purpose of this paper to sketch briefly the manner in which this change in scientific endeavor was brought about, and what it has meant to the civilized world.

THE PRACTICE OF MEDICINE IN ANCIENT TIMES

The practice of medicine existed as a highly developed profession in Babylonia and in ancient Egypt, but direct care of the patient was associated with magic, witchcraft, superstition, and religion. Nevertheless, the Egyptians possessed a formidable materia medica, and many of the remedies have descended to our day. They originated the science of chemistry, and knew of the antiseptic value of extreme dryness as well as of chemicals such as niter and common salt. Egyptian medicine, however, languished and gradually merged with that of Greece.

THE DAWN OF RATIONAL MEDICINE

The dawn of rational medicine began in Greece under the influence and guidance of Hippocrates. He was the first to realize that disease was a part of the processes of nature, and was not divine in origin. With no other instruments than an open mind and keen senses, he classified diseases according to symptoms, emphasized the importance of careful observation, and was ever on the lookout for sources of error, which is the very essence of scientific spirit. Hippocrates was not acquainted with experiment, but he profited by experience. His description of epilepsy, puerperal sepsis, and other diseases would need but little change if printed in the textbooks of today.

Galen continued the Hippocratic method of observation and instituted the first experiments in physiology. Some of his anatomical descriptions were very good, but much of his talent was overshadowed by a tendency to obscure the facts by theoretical dogma. So profound was the effect of his teaching that, up to the time of Vesalius, his word was taken as final in any argument.

MEDICINE DURING THE DARK AGES

After Galen's death, European medicine remained at a standstill, and much was forgotten during the Dark Ages. However, at the time of the Renaissance, medical as well as other sciences were included in the great upheaval. New enthusiasm for Hippocrates and Galen began to flourish; this was largely due to the invention of the printing press. Rapid strides were made in the sixteenth and seventeenth centuries, and anatomy and physiology began to be studied intelligently. The greatest advancement during this period may be attributed to the book on anatomy by Vesalius in which he corrected many of Galen's misconceptions. Great was the furore aroused by this work, and it was many years before its true value was recognized.

THE BEGINNING OF MODERN MEDICINE

Modern medicine may be said to have originated at the time Harvey described the circulation of the blood. Although his discovery was of extreme value in itself, it opened a new field of medicine, for it was the first time that a definite medical problem had been solved by a combination of experimentation and observation. Following the example set by Harvey, rapid strides were made in the basic sciences, such as physiology, anatomy, chemistry, and physics. About this same time the invention of the microscope aroused a mild interest in the invisible world, but it was years before minute organisms and cellular changes in the tissues were associated with disease.

* Read before the general session, California Medical Association, Yosemite, May 13 to 16, 1935.
From the department of surgery, The Mayo Foundation, Rochester, Minnesota.

On the other hand, the curative side of medicine remained in about the same stage as in the time of Hippocrates. The art of observation had been further developed and, as a consequence, many features of various diseases were known and the general knowledge of anatomy had increased. Linnæus set the vogue of classification in medicine as well as in botany, and from this time on, diseases were classified, symptoms were correlated, and descriptions of findings at necropsy were reported. Later, the names of Graves, Bright, Hodgkins, Addison and many others were intimately associated with diseases which were supposed to have been originally described by them. Nevertheless, these men only began to understand how the body functioned, for the cause of disease and rational methods of treatment were still unknown. One exception must be made, however: in 1796, Jenner demonstrated the value of vaccination in cases of smallpox, but one hundred years elapsed before the principles underlying acquired immunity were realized.

CONTRIBUTIONS DURING THE NINETEENTH CENTURY

About the middle of the nineteenth century many of the medical problems which had hitherto persistently resisted all attempts at solution gradually began to fall into their component parts after the discoveries made by Pasteur and Koch. Pasteur, a chemist, became interested in the field of biology through his studies of the fermentation of wine. At the conclusion of his successful work on the silkworm, which proved for the first time that biological problems could be solved by experimental methods, he was carried into the realm of bacteriology by an investigation on chicken cholera. His discovery of preventive inoculation was due to the accidental finding that virulent cultures of chicken cholera virus became inactive upon standing. He then observed that when the chickens which had failed to develop the disease were reinjected with material from fresh cultures, no untoward effects could be detected. When these principles were applied successfully in the treatment of anthrax in animals and hydrophobia in human beings, the science of immunology was born. In 1878 Koch introduced a new method of obtaining a pure culture, and conclusively demonstrated the relation of bacteria to disease. As a result of these discoveries greater advances were made in the next fifty years through experimental methods than had been accomplished in 2,500 years of observation.

DAWN OF MODERN SURGERY

The dawn of modern surgery, while closely related to the work of Pasteur and Koch, was ushered in by Lister, who was the first to visualize the possibilities of antisepsis in the operating room. It has often been said that surgery had almost reached the end of its progress when it was set free by Lister and his contributions, which have been of such great benefit to mankind. However, it should never be forgotten that the field of surgery would have been forever limited had it not been for the discovery of anesthesia. Thus, the surgeons in the nineteenth century, never lacking in skill and possessing a means of alleviating pain as well as a knowledge of the work of Pasteur and Lister, revolutionized their craft to such an extent that within a comparatively few years the entire body was included within its realm.

INFLUENCE OF THE SCIENCE OF BACTERIOLOGY

Before the time of Pasteur and Koch, so far as the curative side of medicine was concerned, there was little to light the pathway for the sick or for those who attended them. However, when microörganisms began to be definitely associated with disease, the minds of men received a new impulse, and their thoughts took a new direction. Consequently, great contributions were rapidly made by a long line of bacteriologists.

Only after the germ that causes *tuberculosis* had been discovered by Koch could mankind hope to eradicate this disease which has killed millions. Prophylactic measures, as well as new methods of treatment, were soon instituted and constantly improved, with the result that the changes in the mortality statistics in this country have been more promising from year to year.

Everyone is familiar with the large ward set aside primarily for the treatment of patients with *typhoid fever* in former days. This situation has entirely changed since the discovery of the Bacillus typhosus by Eberth in 1880. When it was found that chlorin killed the organism, chlorination of the city water supply eliminated one of the greatest sources of danger. In addition, the extensive use of vaccine prepared by Wright and Haffkine, and the improvements in diagnosis described by Widal, have been instrumental in lowering the death rate of typhoid fever to 1.5 per 100,000 of our population. As a result, so few are the cases seen at the present time that a medical student may see only one or two of these patients during the four years of his college course.

At the present time it is difficult to realize that *smallpox* used to claim 600,000 lives each year in Europe, and that in 1792 all of the population of the city of Boston had the disease except those who had had it previously. We have to thank the inquisitiveness and perception of our English country doctor for the methods at our disposal for control of the disease. While it had long been known that a patient who had suffered from cowpox never developed smallpox, no one realized the significance of the observation until Jenner published the results of his experiment. He had applied a small amount of cowpox virus, obtained from the lesion on the hand of a milkmaid, under the skin of a small boy; subsequently, when the boy was inoculated with smallpox virus, he failed to develop the disease. In this enlightened age everyone knows that, owing to the widespread practice of vaccination, smallpox is rare. On the other hand, how many realize that in the United States there were 48,000 cases of this disease in 1930, when there should have been none?

PREVENTIVE INOCULATION

The value of preventive inoculation against various diseases is well illustrated by what has been accomplished in the treatment of *diphtheria*. It is difficult to conceive practicing medicine today without an effective means of curing certain diseases. The new germs discovered in the throats of diphtheric patients by Klebs and Loeffler were found to produce a poison which was fatal when inoculated into animals. However, Behring observed that, if a non-fatal dose was administered, the animals eventually developed an immunity to the poison. He next noted that the blood serum of these resistant animals contained an anti-poison that neutralized the diphtheria poison. When he had successfully proved the value of this serum among human beings suffering from diphtheria, the scourge was chained that had been claiming the lives of half the patients afflicted, constituting thousands of individuals annually. Not many years afterward, following much experimentation on animals, science discovered toxin-antitoxin and toxoid which, when injected under the skin, renders the individual immune to the disease. Nevertheless, in the light of all this knowledge, there were 65,000 cases of diphtheria in this country in 1930. Only three hundred deaths from diphtheria in the city of Chicago was considered an excellent record in 1930; however, in 1933, the number of deaths was reduced to nine through the conscientious effort on the part of the physicians of that city in employing toxin-antitoxin and toxoid. This serves to indicate what might be accomplished by the organized medical profession supported by the public's coöperation.

At present we know more than ever before about the prevention and treatment of such diseases as *scarlet fever, whooping-cough, measles,* and *infantile paralysis*. This last has baffled scientists for many years, but, owing to recent investigations, we not only have a means of combating it, but we soon should be able to prevent by vaccination the crippling effects of this disease.

INSECT-BORNE DISEASES

The devastating epidemics of *malaria*, a disease known to Hippocrates and one that contributed to the fall of the Roman Empire, continued to ravage the civilized world until Laveran discovered the parasite in the blood of suffering patients, and Manson demonstrated the mosquito-malaria relationship. While the disease is still in evidence in swamp-ridden tropical countries, the death rate in America has been reduced to two per one hundred thousand inhabitants.

Following Manson's vision of insect-borne diseases, Reed, Lazear, Agramonte, and Carrol were appointed as a commission to investigate *yellow fever*, which was the disease that drove the populace out of Philadelphia soon after the Revolutionary War. After a prodigious and courageous search, during which Lazear lost his life while permitting himself to be used as an experimental subject, the etiologic agent of yellow fever was found to be carried by the mosquito (colopus). As a result of the commission's report, the United States Public Health Bureau, through the medium of rigid hygienic measures, has completely rid the country of this dangerous menace.

The knowledge of *protozoan and bacterial diseases* was put to a valuable test in 1904. Pestilence had played a large part in defeating past attempts to build the Panama Canal, and so the United States appointed a Health Commission to study the situation before it undertook the project. Malaria and yellow fever were banished, and dysentery was kept under control. In less than two years the mortality among the workers was materially reduced, being one-third of what it formerly had been. This is an excellent example of statesmanship directed by medical science.

Time does not permit a description of the methods by which typhus fever, the plague, and many other devastating diseases were conquered; nevertheless, sufficient has been said to indicate the extent of our indebtedness to the ones who carry out these researches.

THREE FACTORS IN THE DEVELOPMENT OF RESEARCH

Previous history having taught the value of experimentation, tremendous progress was made in our knowledge of the functions of organs and associated diseases not caused by bacteria. Research must advance through three essential steps before success is certain. After discovering the presence of a disease, its nature and cause must be determined. Usually the second step is to reproduce the disease in animals in order to learn how to prevent and treat it. Then, after the preliminary experiments in animals have been completed, the results are applied to man. In most instances success comes only after years of ceaseless, painstaking effort on the part of many men. Research cannot be hurried, for each man, before offering a contribution, must grope through darkened byways until the ultimate goal is reached and the average life span is increased one or two years more.

COMMENTS ON DISCOVERIES HAVING TO DO WITH CERTAIN DISEASES

Claude Bernard was the founder of the artificial production of disease by means of chemical and physical manipulation. It was he who coined the term "internal secretion," in describing his remarkable discovery of the *glycogenic function of the liver*, which has been of inestimable importance. Up to his time, gastric digestion constituted the sum total of the physiology of digestion. He cleared up the entire subject by showing that the gastric juice merely prepared the food for the digestive ferments produced by the pancreas, and he thereby laid the foundation for our studies on digestion and nutrition. In addition, the success which we have attained in the treatment of hypertension, Raynaud's disease, scleroderma, and other allied conditions, may be directly attributed to his discovery of the vasomotor mechanism.

The records of a Greek physician, Alexander Trallianus, show that *gall-stones* were recognized as an entity in the sixth century. In ancient times

bile and gall-stones were thought to cause remarkable cures when used as therapeutic agents. For instance, Rhases, an Arabian physician, about 900 A. D., wrote that the stones from the gall of an ox were ground up and drawn into the nostrils to promote sharpness of vision. If stones were not available, the bile of a black ox might be substituted. It was thought that if an animal had gall-stones it was suitable for eating; but if the calculi had sharp edges, the animal was unfit for food. In the thirteenth century it was recorded that "some animals have no gall-bladder at all; some have the gall-bladder in the belly, and some have it in their ears." In ancient Babylon the idea arose that future events could be predicted by the condition of the gall-bladder of a sacrificial animal: if the right side of the gall-bladder appeared swollen, it pointed to an increase in the strength of the King's army. Swelling of the left side was considered an indication that the enemy was likely to be successful. In our day, mention of the biliary and digestive tracts recalls the names of Mann, Bollman, and their associates, for they have made some of the outstanding contributions to the knowledge of the physiology and pathology of the gall-bladder and liver. Mann was among the first to produce chronic peptic ulcer experimentally. This led to a more thorough understanding of the processes involved in the etiology and treatment of that condition. Their more recent studies on blood flow indicate that we may look forward confidently to revealing information on that subject.

All of us have friends who are enjoying life but who, except for the discovery of insulin, would be dead or existing only in a starved and miserable state. The cause of *diabetes* was established for the first time when, in 1889, two scientists removed the pancreas from a dog and produced this disease. However, it was not until a little more than ten years ago that Banting and his co-workers succeeded in isolating the hormone produced by the islands of Langerhans, which hormone is lacking in diabetic patients. Children having this disease formerly died in one or two years, but they now grow into healthy men and women. The life of adult diabetics has also been definitely prolonged. Statistics reveal that there are at least two million people in the United States alone who have benefited by this discovery.

That dreaded disease, *pernicious anemia,* has also been conquered in the past few years. The discovery of the value of liver therapy was the direct outcome of years of work by Whipple, Minot, Murphy and Robbins, who were endeavoring to learn the value of different diets in the treatment of experimental anemia in dogs and rats. As a result of their endeavors, thousands of individuals who formerly were doomed to slow but sure death can be maintained in excellent health at little inconvenience to themselves.

The advances in the mode of recognition and treatment of *diseases of the thyroid gland* during the past twenty years constitute a record of achievement as brilliant as any our age can boast. Parry, in 1825, and Graves, in 1835, gave accurate descriptions of hyperthyroidism, but it was not until 1886 that Möbius definitely ascribed the condition to an abnormality of the thyroid gland. The next step in advance was made by Müller, in 1893, when he found that the output of nitrogen in exophthalmic goiter considerably exceeded the intake. This was followed in 1895 by the work of Magnus-Levy, the outcome of which was a study of the basal metabolic rates of these individuals. Kendall finally succeeded in isolating thyroxin in crystalline form in 1914. Subsequent research by Kendall, Plummer, and Boothby resulted in the revelation that "thyroxin is a catalytic agent, hastening the rate of formation of a quantum of potential energy available for transformation on excitation of the cells." As a result of the combined efforts of these men, another drug was added to the therapeutic agents at the physician's disposal in the treatment of disease; for prior to this time the apathetic appearance and imbecility associated with myxedema were irremediable. Then, in 1922, Plummer introduced the use of iodin in the preoperative preparation of patients suffering from exophthalmic goiter. It may be said that this treatment with iodin has placed the surgery of exophthalmic goiter on a sound basis by reducing the severity of all of the manifestations of the disease, and by eliminating the long-feared and dangerous surgical complications. Thus the obstacles to surgery in this field finally yielded before the persistent efforts of a comparatively few men.

The *suprarenal glands,* regarded by the ancients as possessing miraculous powers and described by Addison from the clinical standpoint, are now known to produce at least two hormones. The value of one of these, epinephrin, has been demonstrated; but it was only recently that Kendall was able to isolate in crystalline form the other, which is essential to life. From his preliminary work with human beings as well as with dogs, it appears that yet another fatal disease has been mastered by providing substitution therapy.

Little was known of the minute parathyroid bodies until MacCallum demonstrated their relationship to calcium metabolism in 1908. Another twenty years went by before Hanson, a general practitioner interested in chemistry and working in his laboratory in spare moments, actually isolated the active hormone. Collip later substantiated Hanson's work, and proved the value of the preparation in the treatment of those unfortunate individuals suffering from parathyroid tetany.

In addition to the work already considered, that on the pituitary body, thymus, and sex organs, indicates that we may confidently look for even more revealing and valuable discoveries in these fields in the near future.

VALUE OF THE KNOWLEDGE ACQUIRED FROM THE EXPERIMENTS OF CHEMISTS AND CHEMICAL PHYSICISTS

As men of science, it is not difficult for us to appreciate the revolutionary changes in the civilized world which have resulted from the experiments conducted by the chemist and chemical

physicist. Without their aid the age of electricity would not have been possible, nor would we have the diagnostic and therapeutic uses of roentgen-rays or radium. The organic chemist has not only shed light on the complex processes occurring in the body, but has also produced many therapeutic agents. It is difficult for us to conceive of practicing without cocain, novocain, salicylic acid, acetanilid, eserin, pituitrin, salvarsan, and innumerable other drugs, all of which are of comparatively recent origin. A new era in the diagnosis and treatment of deficiency diseases was ushered in through the discovery, mainly by biochemists, of the vitamins which are so essential to life.

CIVILIZATION'S OBLIGATIONS TO RESEARCH WORKERS

This presentation has necessarily been brief, and many important findings have been omitted; likewise, much of the routine work has been overshadowed by the spectacular. However, we also wish to pay tribute to those individuals whose contributions have been of inestimable value to the medical profession. Some of the greatest contributions have been made by those who work single-handed while engaged in an active practice, and too often at great physical expense. In the present rather revolutionary period, many changes in our methods of practice have been suggested. Too often in time of turmoil the distractions outweigh the incentive, and it is impossible to progress with maximal efficiency. Research has been defined as "a method of keeping everyone reasonably dissatisfied with what he has." There never was a greater need for original investigation, or a better opportunity to salvage time for it than the present.

PURE SCIENCE INVESTIGATION AND CLINICAL OBSERVATION ARE BOTH IMPORTANT

Much has been written concerning the methods that should be employed in conducting original investigation, but it should be pointed out that, although there are some fields of study best left in the hands of the so-called pure scientists, research is not confined to the laboratory worker alone. Accurate observation of signs and symptoms, and their correlation with disease, will always be essential. In addition, there are certain phases of research which cannot be conducted by the laboratory investigator. The study of the earliest changes in disturbed function, which later develop into a definite clinical entity, lies solely within the realm of the family physician. Moreover, the science of prognosis and the evaluation of therapeutic remedies when applied to man necessitate an acuteness of observation during the progress of the disease which the scientists alone cannot appreciate. There can be no doubt that, although closely related, the fields to be conquered by laboratory methods and curative medicine are different. In order to progress with maximal efficiency, not only must observatory and experimental methods be coördinated, but there must also be an intimate contact between the investigators and the disease as it exists in man.

IN CONCLUSION

In conclusion, it seems to be in order to determine the results of all this knowledge which we have struggled so long and so diligently to obtain. One would be making a conservative estimate in stating that there are fifty million people in this country today whose lives have been saved or prolonged through medical science. While there are those who might question such an assertion, the figures are easily arrived at. One hundred years ago the average span of life was thirty-five years; today it is sixty. Since there are 126,000,000 people living in these United States, it is a simple problem to calculate the number of individuals whose existence at the present time is dependent upon the measures which have been instituted to prolong life. Moreover, seven years have been added to the average life span in the last twenty-three years, for in 1911 the average length of life was only fifty-three years. This also means that there are 13,000,000 people alive today who would have been dead but for the progress made in medical science. At the present rate of increase in knowledge, man can look forward to an average of sixty-five years of life by 1944. The battle in which we are active participants will never cease, for the diverse ramifications of our science are bound to hold our interest. However, it is the judicious employment of these days that will continue to advance the front of our knowledge during this period, and speed it on its way to even greater heights.

The Mayo Foundation.

THE DIFFERENTIAL DIAGNOSIS OF INTRACRANIAL DAMAGE*

By E. J. Morrissey, M. D.
San Francisco

Discussion *by Howard C. Naffziger, M. D., San Francisco; Carl W. Rand, M. D., Los Angeles; Howard W. Fleming, San Francisco.*

THE symptoms and signs of cerebral injury may result not only from intracerebral lesions, namely, concussion, contusion, laceration and intracerebral hemorrhage, but also from cerebral compression due either to depressed fractures, extradural or subdural hemorrhages.

DIFFERENTIAL DIAGNOSIS

The differentiation between these conditions is the essential point in determining the method of treatment.

Concussion.—Unfortunately in the past the term concussion has been used in a very elastic manner to include severe cerebral contusion and even laceration.

At present it is customary to designate as concussion head injuries in which no definite pathological changes are apparent.

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* From the surgical service of Stanford University, San Francisco County Hospital, Department of Public Health.

Read before the General Surgery Section of the California Medical Association at the sixty-third annual session, Riverside, April 30 to May 3, 1934.

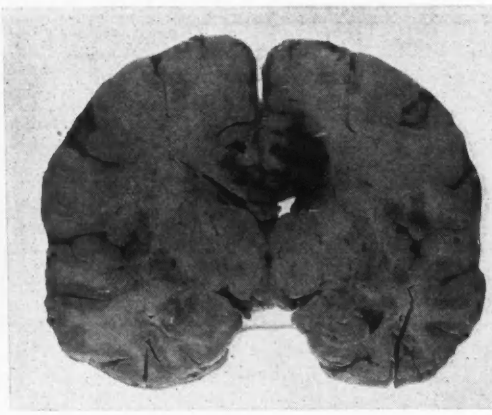

Fig. 1.

Fig. 2.

The term, however, will probably be discarded. I am certain that as our methods of investigation advance we will be able to demonstrate pathological changes in those specimens that are now considered as normal.

As a result of the studies of Cajal and others, this has already in part been accomplished.

Contusion.—Contusions of the brain may vary from a few petechial hemorrhages to extensive bruising of the cortex and underlying tissues.

The petechial hemorrhages have a tendency to group themselves about localized areas. (See Fig. 1.) This grouping is one of the distinguishing points between petechial hemorrhages resulting from trauma and those following emboli, infection, etc. (See Fig. 2.)

Laceration.—Laceration of the brain is a definite tearing of the tissues, and is naturally associated with hemorrhages into the surrounding brain tissue, and usually into the subarachnoid and subdural spaces.

Lacerations may be found at any point, but they are especially common over the bases of the frontal and temporal lobes. They may be directly under the point of injury, but are usually *contrecoup.*

Hemorrhage.—Extracerebral hemorrhage may be either extradural, subdural (acute or chronic), or subarachnoid.

Extradural Hemorrhage. — Extradural hemorrhage practically always results from a rupture of the main trunk or one of the branches of the middle meningeal artery.

In rare instances it occurs from either a tearing of one of the large venous sinuses or a separation of the dura from the skull at the time of the accident, with bleeding from the bone.

The bleeding from the torn vessel or vessels strips the dura from the skull, and as the hemorrhage enlarges symptoms of compression ensue.

Extradural hemorrhages, as a rule, are disc-shaped, thin at the margins and thick in the center. They may be of any size, varying in weight from a few to over two hundred grams.

Moody, in one hundred autopsies, found the average weight of the clot in fatal cases to be one hundred and ten grams.

The majority of extradural hemorrhages occur in patients between the ages of twenty and fifty. They are rare in childhood and elderly people. In Vance's series of sixty-one cases only three occurred before the age of twenty.

As a general rule the symptoms resulting from these hemorrhages make their appearance within the first twenty-four hours. The time interval may vary, however, from a few hours to several days, depending entirely on the rapidity with which the dura is stripped from the bone.

Subdural Hemorrhages.—When the force of the blow is sufficient to cause either severe cerebral contusion or laceration of the cerebral veins with tearing of the arachnoid, we have bleeding into the subdural space.

These subdural hemorrhages may be either unilateral or bilateral, and likewise may vary in size from a small localized clot to a large hemorrhage sufficient to cause marked cerebral compression.

Vance, in 512 autopsies, felt that death was due to cerebral compression by a large collection of dural blood in 132 cases. The average weight of the clot was 61.1 grams.

Chronic Subdural Hematomas.—Chronic subdural hematomas differ from the acute subdural hemorrhages spoken of above and lie, as Virchow was the first to show, in the subdural space. They are surrounded by a definite capsule and are often bilateral.

Trotter and others believe that the bleeding is due to injury of the veins passing from the brain to the tributaries of the superior longitudinal sinus.

In the great majority of cases they occur some time after what was apparently a very minor head trauma. This period, between the injury and the development of symptoms, may vary from a few weeks to several months or even years. Often the initial injury is so slight and the elapsed time before the start of symptoms so long that it is entirely forgotten.

TABLE 1.—*Differential Diagnostic Points*

	Contusion Laceration	Extradural Hemorrhage	Chronic Subdural Hematoma
Unconsciousness	Immediate	Stupor coming on after a latent period. If initial injury severe latent period may be absent.	Latent period varies from few weeks to many months.
Temperature	Fall at first due to shock. Rise following depending on severity. When above 104 degrees recovery rare.	No rise.	No rise.
Pulse and Respirations	Rapid in shock. Slow in medullary involvement. Rapid in medullary failure.	Slow.	Slow.
Blood Pressure or Pulse Pressure	Increase with medullary involvement.	Increased.	No increase.
Spinal Fluid	Contains blood—amount depends on severity. Pressure varies.	No blood unless contusion or laceration present. Pressure increased.	Either slightly blood tinged, xanthochromic or clear.
Neurological Findings			
(a) Weakness or paralysis	Immediate.	Late and progressive.	Gradual and progressive. Occasionally on same side as hemorrhage.
(b) Pupils	Very dilated on side of lesion. Dilated and fixed prognosis poor.	Dilated as a rule on side of hemorrhage.	Often dilated on side of hemorrhage.
(c) Ophthalmoscopic	Negative first 24 hours at least.	Negative.	Bilateral choked discs usually present; greater on side of hemorrhage.
X-ray Findings	Fracture may or may not be present.	Fracture line crossing middle meningeal groove usually present.	Usually no fracture. Pineal shifted.

Following the latent period we have the history and findings of gradually increasing intracranial pressure, namely, headache, nausea and vomiting, visual disturbances, choked discs, etc. In view of these facts, it is extremely important in any case of gradually increasing intracranial pressure to go carefully into the past history.

Subarachnoid Hemorrhages.—Bleeding into the subarachnoid spaces occurs in practically all cerebral contusions of any severity.

It varies from merely a slight pinkish discoloration of the cerebro-spinal fluid to the point where it is practically pure blood.

Essick, Bagley, Fay and others believe that this condition accounts for adhesions and blockage of the circulation of the cerebro-spinal fluid, and many of the post-traumatic cerebral symptoms.

Subdural Collections of Cerebro-Spinal Fluid.—A discussion of the differential diagnosis of intracranial lesions would not be complete without mention of the localized subdural collection of cerebro-spinal fluid first spoken of by Naffziger. These cases present symptoms and findings very similar to extradural hemorrhages.

SPECIAL SYMPTOMS

Unconsciousness. — The duration of the period of unconsciousness immediately following a head injury is in direct proportion to the severity of the cerebral damage.

The general rule may be laid down that the longer the period of unconsciousness, the more severe the cerebral contusion or laceration and the more guarded must be the prognosis.

Occasionally we see deaths resulting in patients who were not unconscious following the accident. In these cases it is practically always due to some complication, such as subdural or extradural hemorrhage, meningitis, etc. There is, of course, the occasional case of continued bleeding into the cerebral tissues following a laceration.

Stupor, coming on gradually after a period of consciousness, is practically always the result of an extradural hemorrhage. The period of consciousness is spoken of as the latent period and may vary from a few minutes to hours or even days.

It must always be borne in mind, however, that the initial period of unconsciousness due to the contusion may be of sufficient length that it overlaps the unconsciousness resulting from the hemorrhage, and that, therefore, there will be no latent period.

Temperature.—The temperature rise within the first twenty-four hours is likewise a fair indication of the amount of cerebral contusion or laceration. In the average case, immediately following the injury, there is a fall in temperature, the result of shock followed by a rise above normal.

In those cases in which recovery takes place the average varies between 101 and 103 degrees. As a rule recovery seldom occurs when, as a direct result of the cerebral trauma, the rise is above 104 degrees.

Pulse and Respirations.—The point has always been emphasized that slowing of the pulse and respirations, especially when associated with rise

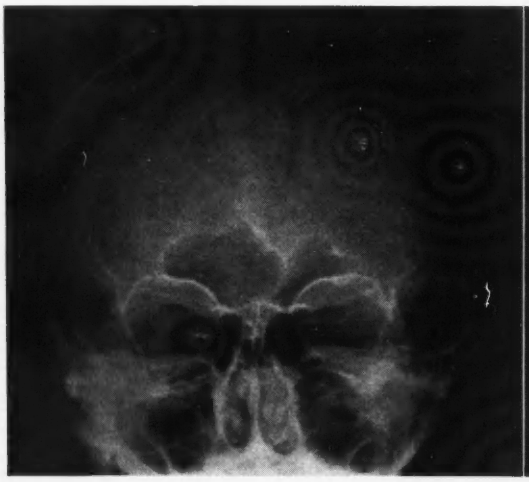

Fig. 3.

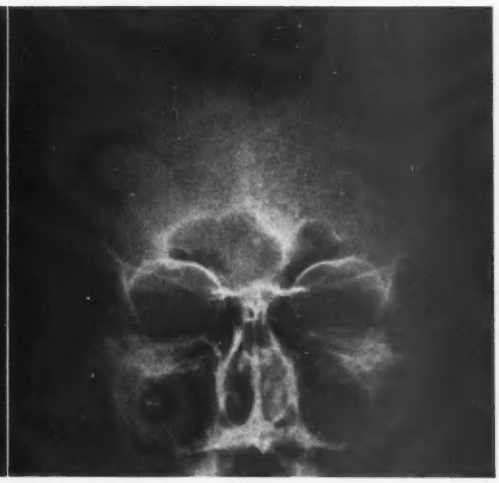

Fig. 4.

in blood pressure or a widening pulse pressure, is indicative of increased intracranial pressure.

This is not the entire truth. What this syndrome indicates is medullary involvement.

Before this was realized, one occasionally was surprised, at operation or postmortem examination, to find the brain shrunken and fallen away from the dura in those cases that had marked slowing of pulse and respirations. The measurement of the spinal fluid pressure is a good indication as to whether or not these medullary symptoms are due to increased intracranial pressure.

It is extremely important to bear the above point in mind when the question of dehydration is considered in the treatment of head injuries.

Slowing of pulse and respirations, with a rise in blood pressure or widening pulse pressure, when due to increased intracranial pressure is a result of either brain edema or hemorrhage.

If it occurs within the first twenty-four hours it is most likely due to an extradural hemorrhage. In Vance's series of postmortem examinations, on 106 cases of extradural hemorrhage, death occurred in over 50 per cent within the first twenty-four hours.

When the symptoms make their appearance after the first twenty-four hours they are more likely to be the result of cerebral edema, secondary to contusion or laceration.

On the other hand, when we have these findings occurring weeks or months after an injury, we may with certainty make a diagnosis of a subdural hematoma.

NEUROLOGICAL EXAMINATION

A careful neurological examination made immediately following the accident is the best method of distinguishing between lesions due to contusion or laceration and those resulting from hemorrhage.

If immediately following cerebral trauma there is a weakness or paralysis with definite reflex changes, then it is no doubt the result of contusion or laceration.

On the other hand if the first examination is negative and subsequent findings reveal a gradually developing paresis, especially starting about the face, then it is most probable that we are dealing with an extra- or intradural hemorrhage. Occasionally, however, this picture is presented by increasing edema about a laceration or an enlarging subcortical hemorrhage.

The pupillary findings are extremely important. They are valuable both from a prognostic and diagnostic point.

Patients with bilaterally dilated and fixed pupils very seldom recover. In Blakslee's series of 610 cases of fracture of the skull with bilateral dilated and fixed pupils, 95.5 per cent died. The existence of previously fixed pupils must, of course, be kept in mind.

Unilateral dilatation with fixation of the pupil occurs as a rule on the same side as the cerebral involvement and may be due to either cerebral contusion or extradural hemorrhage.

A gradually developing unilateral dilatation of the pupil is more likely the result of an extradural hemorrhage. Occasionally it is the only positive localizing sign. This point has been emphasized especially by Holman and Scott, Lyerly and others.

Evidence of choking of the optic discs is extremely rare in the first forty-eight hours, even though there be fairly marked increased intracranial pressure. Ophthalmoscopic studies should be made as soon as possible, because then we are in a position to note the early signs suggesting increased intracranial pressure such as engorgement and tortuosity of the veins, blurring of nasal margins and hyperemia of the discs. A choking of the discs, on the other hand, is a common finding in chronic subdural hematoma.

A mydriatic should not be used within the first few days because one is then unable to follow pupillary changes which are extremely important.

SPINAL PUNCTURE

Measurement of the pressure and the examination of the spinal fluid is extremely important. Blood in the spinal fluid is found in practically every cerebral contusion of any severity and in all lacerations. As a rule the more severe the cerebral injury the higher the percentage of blood in the spinal fluid. Likewise the more guarded must be the prognosis.

If clear spinal fluid is obtained in a patient presenting the signs and symptoms of increased intracranial pressure then we are more than likely dealing with an extradural hemorrhage.

It does not follow, however, that the presence of blood in the spinal fluid rules out an extradural hemorrhage. Very often cerebral contusion is also present.

The diagnosis of meningitis is likewise verified by examination of the spinal fluid. It must be remembered, on the other hand, that blood in the spinal fluid, especially in the region of the posterior fossa, will cause the usual signs suggesting meningitis, namely, stiffness of the neck and bilateral Kernigs.

ROENTGEN-RAY FINDINGS

Everyone recognizes that there is no direct relationship between the degree of brain injury and the presence or absence of a fracture, and that patients who are in extremely poor condition or in shock should not be subject to roentgen studies. However, we often obtain valuable information which enables us to make a diagnosis.

Extradural hemorrhages occur in the absence of fracture, yet they are much more likely to be present with a fracture crossing the grooves of the middle meningeal artery or its branches. Occasionally, in an unconscious patient, the presence of a fracture crossing one of these grooves is the most important deciding and localizing factor.

What has been a great aid to us in making a diagnosis of a hemorrhage either extradural or subdural is the shifting of the pineal body. It has been useful especially in those cases in which the hemorrhage is on the same side as the symptoms. Fig. 3 illustrates the shifting of the pineal in a large subdural hemorrhage and Fig. 4 the return to normal position after removal of the hemorrhage.

Occasionally we find, associated with cerebral contusion or laceration, a hemorrhage either extra or intradural and of sufficient size to in itself produce symptoms of cerebral compression. These cases are extremely difficult to diagnose, because the symptoms and findings of one tend to mask those of the other.

Le Count and Apfelbach, in reporting a series of extradural hemorrhages, made the statement that only 52.26 per cent were of sufficient size to cause death; and as stated, Vance, in 512 autopsies, felt that death was possibly due to cerebral compression by a collection of subdural blood in 132 cases.

When the above is encountered the question always arises as to whether or not a certain percentage of those cases would have recovered from the cerebral damage were the extra burden of the hemorrhage removed.

A diagnosis, if it is to be made, demands careful observation with frequent neurological examination for evidence of change. One has no right to assume, because he finds bloody spinal fluid and other evidence of cerebral contusion or laceration, that all the ensuing symptoms are a result of this lesion.

If there is any question, trephine openings should be made. By our present methods there is no shock associated with this procedure, and if a hemorrhage is found and evacuated, the patient has a far better chance to recover.

I would rather operate on a patient and not encounter a hemorrhage than to find at postmortem that a hemorrhage had been overlooked.

909 Hyde Street.

DISCUSSION

HOWARD C. NAFFZIGER, M.D. (University of California Medical School, San Francisco).—The statistical points quoted by Doctor Morrissey are helpful in forming our clinical judgment and in prognosis. The management of craniocerebral injuries does not require particularly refined methods of neurological examination, nor does the state of the patient usually permit them.

Proper interpretation of the physiological disturbances of consciousness, of respiration, heart rate, and blood pressure are of paramount importance. By these and the gross neurological manifestations, our treatment is guided.

The physiological responses to acute cerebral compression have been well established in laboratory experimentation. In our patients, however, these well-known alterations may be lacking, and we may find bizarre responses to brain compression. For example, an increasingly rapid pulse may be associated with a rising intracranial pressure instead of the expected slow pulse. In such instances we are dealing with the reactions of a traumatized and contused brain—one which behaves differently from the untraumatized but otherwise normal brain, which is being subjected to gradual compression in the experimental animal.

Doctor Morrissey's presentation makes clear, I think, that only a small proportion of patients with craniocerebral injuries are benefited by operation.

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CARL W. RAND, M. D. (523 West Sixth Street, Los Angeles).—Doctor Morrissey has given a very excellent differential diagnosis of the various types of intracranial hemorrhages following head injury. His reference to the pineal shift in certain cases of chronic subdural hematoma and of large subdural hemorrhages is timely. It is felt that x-ray plates should be studied more carefully for the possibility of pineal shift in suspected cases of intracranial hemorrhage.

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HOWARD W. FLEMING, M. D. (384 Post Street, San Francisco).—Doctor Morrissey's paper on "The Differential Diagnosis of Intracranial Damage" is most timely.

No diagnostic problem is more open to controversy. Recently, well-known authorities have expressed their opinions as to the diagnosis and treatment of head injuries in a most dogmatic manner. Diametrically opposed methods have been advocated so forcefully that the medical profession is at a loss to know how to treat their cases. Only too frequently this indecision leads to procrastination, and opportunities for effective therapy are overlooked.

Judicial use of all recognized methods will result in a far greater percentage of correct diagnosis. There

is no substitute for a careful history followed by frequently repeated examination. Spinal puncture and x-rays often are helpful. Each case is an individual problem, but careful evaluation of all information to be obtained usually suggests the nature and extent of the intracranial pathology.

The methods and conclusion, as given by Doctor Morrissey, are those generally accepted by the great majority of neurological surgeons.

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DOCTOR MORRISSEY (Closing).—In conclusion, I wish to thank the various men who have discussed this paper, and emphasize the fact that each case is individual in itself, and that one should not adhere too closely to any general rule.

URETHRAL STRICTURES—A RÉSUMÉ OF TREATMENT*

By WILBUR B. PARKER, M. D.
AND
CHESTER H. MACKAY, M. D.
Los Angeles

DISCUSSION *by Elmer Hess, M. D., Erie, Pennsylvania; Henry A. L. Kreutzmann, M. D., San Francisco; Albert M. Meads, M. D., Oakland.*

THE great amount of current literature on the diagnosis of urethral strictures leads us to believe that the procedures of our preceptors were, and are today, just as accurate, and in many instances more accurate than the teachings of more recent authors. The older methods comprehended at the start an accurate clinical history, palpation, and a soft rubber catheter.

PROCEDURE WITH OBSTRUCTIONS

When obstructions are met by these simple methods, the following procedures must be resorted to:

Calibration of the urethra by use of button-sounds and button-bougies. Further, in attempting to calibrate the urethra, a size number 6 or larger should be used first. If unable to pass any of these sizes, smaller types should be attempted, down to a filiform, to be used if necessary. By this method the size, number and location of strictures can be determined.

Gentle instrumentation should be the watchword for all urologists, in diagnostic or treatment procedures. The less traumatism, the less the possibility of occurrence of complications. This rule should apply to all classes of strictures, both in male and female patients, and irrespective of their locations.

Urethrograms, whatever the opaque medium used, have been made much of in medical literature, to assist in the diagnosis and location of urethral strictures, regardless of fallacious interpretations. We must admit that a great many of the newer researches have had a scientific playground. Urethral strictures are as plentiful in number at the present time, as they have been in the past, and will continue to be so long as the human race may exist.

DEVELOPMENT OF URETHRAL STRICTURES

Time elements in the development of urethral strictures may be classified as: (1) Congenital, designated by the term that now exists and a type that does not contract; (2) Traumatic; (3) Inflammatory.

Urologists should hope to see the day when no adolescent or adult, male or female patient with a congenital stricture, will apply for treatment for a urethritis, specific or nonspecific. Without doubt they are the most unfortunate class of victims, including urethral chancre, that we have to treat today.

Traumatic strictures depend upon the amount of damage done to the urethra at the time of accident. In comparison with strictures of inflammatory origin, time of formation is much shorter. Inflammatory strictures contract slowly, depending upon the severity of the urethral infection and whether there have been any complications of the urethritis. It has been said that about one-third of inflammatory strictures occur within one year after infection, while two-thirds or more occur within two to four years.

The most frequent sites of congenital strictures are at the external meatus. Inflammatory strictures occur mostly in the phallic, bulbous and membraneous urethras, rarely in the posterior urethra. Spasmodic strictures have been denied as to whether they ever occur in the phallic and membraneous urethras. Stricture plus spasm lead to acute retention, an entity which we cannot deny. Traumatic strictures occur any place along the site of trauma, and this rule holds true in female strictures, despite the anatomical differences between the two sexes.

TREATMENT

Surgical and non-surgical treatment in private and institutional practice is usually somewhat different.

Patients in private practice are instructed to report as often as needed, in order to carry them from a filiform size to a No. 22 or No. 24 French-size dilator. Progress is often slow, and very often in the contracting types a period of six months or over is required to accomplish a successful result. Patients with filiform types of strictures are advised to report daily, until such times that it is possible to use other than filiforms. Following the filiform treatments for gradual slow dilatation, small bougies are used. In our experience, this method has caused less disturbance to the voiding ability of the patient.

Institutional patients are generally those that have been badly traumatized, and are suffering from acute retention. Such patients should be given indicated sedatation, for they rarely tolerate satisfactorily a local anesthesia, owing principally to spasm or complete occlusion at points of obstruction. For such patients, attempts are made to pass some type of catheter, preferably a Coude or natural curve type. Hospitalization usually follows, pending the reaction of the patient to relief and dilatation. If response to treatment is favorable—meaning reasonable ability to void—

*Read before the Urology Section of the California Medical Association at the sixty-third annual session, Riverside, April 30 to May 3, 1934.

the patients are instructed to report regularly to the out-patient department for further relief and dilatation, and advice as to the safest course to follow.

The operative procedure in any particular case is selected from one of the various types of operation such as the emergency indicates: suprapubic cystotomy, external urethrotomy, internal urethrotomy and possibly total resection of the strictured portion of the urethra.

Rarely does a urologist in private practice see a urinary extravasation, unless it follows trauma to the urethra or bladder. This type of injury requires immediate surgical intervention, with cystotomy and free drainage of the tissues involved.

As regards the divulsion and evulsion of strictures by forcible means, we are personally opposed to such measures. The so-called temporary relief, and the immediate misery to the patient gives one guarantee only—"When you have to seek future relief, you will be in a worse condition than when we last saw you." Fortunately, at the present time, such treatments are rarely resorted to.

Quite frequently cystotomy alone will reduce the inflammation at the site of the stricture, to allow dilatation to be attempted by the methods most suited to the particular case.

In all our experiences, including those of Dr. Granville MacGowan, who was our preceptor for the longest time, we can truthfully say that there are successful and humane methods of treatments for urethral strictures.

The laboratory, which can furnish blood chemistry reports in four to six hours, has been an invaluable aid in effecting decision as to risks and the best methods of relief.

In our experience, urinary extravasation caused by strictures of the urethra have been the most difficult to deal with. Out of twenty-five cases in the General Hospital, we lost four patients, even though one was operated three times within one year for the same reason. After the third operation, with a well-dilated urethra, he lost a testicle due to eversion. Our first fatal case in private practice was due to septicemia. The mortality rate in patients, including all classes of strictures, with treatment ranging from filiform size to actual resection, in some two hundred cases is not over 8 per cent.

The care of the various types of urethral strictures require much equipment. This fact is well appreciated by urologists. In one sense, it is regrettable that not infrequently urologists who do keep available all the necessary equipment do not get the first opportunity toward the relief of patients. Despite this fact, on many occasions urologists have been able to render relief under circumstances that were most unfavorable.

The treatment of strictures of the urethra have been successful except in three types: first, those caused by extensive trauma, as cases with multiple fractures of the pelvis and loss of urethral continuity; second, the non-coöperative patient; third, those who would not, or did not, report at regular intervals for a check on their calibration.

Except in a few instances of early filiform strictures, and an occasional resection type, we believe, there is no permanent cure for strictures. The saying, "Once a stricture always a stricture," still holds true, except as mentioned above. No patient can be classed as successfully cured as long as he lives, unless he or she reports regularly for examination and appropriate treatment.

527 West Seventh Street.

DISCUSSION

ELMER HESS, M. D. (8 East Twelfth Street, Erie, Pennsylvania).—This is a most timely paper. I know of no condition that is so poorly treated as strictures of the urethra, and the essayists have rightfully emphasized the one and only important thing, in my opinion, in the treatment of this condition, namely, gentle instrumentation.

How often the urologist sees patients with ruptured urethras, false passages, and extravasation of urine, due to the effort of some physician to relieve the terrifically overdistended bladder of an acute retention; and what we say here about strictures of the urethra applies equally in hypertrophies of the prostate.

It seems to me that, for the most part, practitioners of medicine who see these stricture cases first should be willing to refer such patients to a competent urologist for, at least, preliminary treatment. I would venture to say that, if this were done, the subsequent treatment could be very well carried out by the general physician, and that the accidents of that preliminary instrumentation would be reduced 95 per cent.

The authors regard devulsion and evulsion of strictures by forcible means as contrary to good practice. I believe that any competent urologist feels exactly as they do, and I was delighted to hear the remark that "quite frequently cystotomy alone will reduce the inflammation at the site of the stricture, to allow dilatation to be attempted by the methods most suited to the particular case." I would like to add to that statement that the period of time desirable to wait after the cystotomy and before attempting dilatation, is from seven to twenty-one days, depending entirely upon the condition of the patient.

It is a delight to see that the teachings of that grand old man, Granville MacGowan, have been so thoroughly drilled into those men who were associated with him that they take what I call the modern attitude in the treatment of this clinical entity, so very common and very difficult to treat.

"Once a stricture always a stricture," is a slogan that should be impressed upon the mind of every man who is called upon to treat this condition. Every patient, whether male or female, who has once had a stricture of the urethra should report to a competent urologist at least once a year, and if necessary oftener, to keep the caliber of the urethra sufficiently open so that there is no back-pressure when the urine is voided, and so that no inflammatory reaction may take place to further lessen the caliber of the channel.

Eternal vigilance on behalf of the victim, and eternal intelligence upon the part of the physician are necessary if these people are not later on to have genito-urinary pathology that may be a menace to both health and life.

*

HENRY A. L. KREUTZMANN, M. D. (2000 Van Ness Avenue, San Francisco).—The authors are to be commended for the sane and conservative viewpoint they have taken in the diagnosis and treatment of urethral strictures. Gentleness in manipulation, as they have emphasized, is of paramount importance. The brutal evulsion by large sounds is to be condemned as an unsound surgical procedure, causing more scar tissue and at times false passages. I am entirely in accord with their statement that the injection of an opaque medium into a badly strictured urethra is of little diagnostic value. Moreover, the grave complications which may result, even when only moderate pressure is used, should guard us against the routine use of this method for diagnostic purposes. We should always bear in mind the possibility of the solution penetrating

the urethral wall and entering the blood stream. This possibility is in direct proportion to the amount of pressure used.

Shortly before this meeting, I saw sections from a patient who had died about half an hour after olive oil had been injected into the urethra as a lubricant. The pressure had ruptured the weakened mucous membrane and, in consequence, the oil had been given intravenously. There was not a single organ in the body that did not contain globules of oil.

At present most traumatic strictures are the result of automobile accidents. Here we find that the descending ramus, acting like a guillotine, causes partial or complete severance of the posterior urethra. This not only results in the formation of a severe stricture, but may leave the patient impotent. I should like to hear what treatment has been most successful in the authors' hands in these cases. Immediate suprapubic cystotomy with the retrograde passage of a urethral catheter has given me the best results.

The authors have made no distinction of strictures occurring in the female and in the male. In the former excellent results are obtained and permanent cures are the rule; whereas in men their dictum of "once a stricture always a stricture" is, unfortunately, the conclusion of all who do urological work.

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Albert M. Meads, M. D. (251 Moss Avenue, Oakland).—Any pathological condition that gives rise to an 8 per cent mortality deserves attention. Therefore, the authors' paper can stand careful reading by all physicians, particularly the general practitioner who sees the larger percentage of urethral strictures first. I am glad that they have emphasized that there is no short-cut method of curing this distressing condition, but that the time-honored procedure of slow dilatation over a long period of time, with a lifetime follow-up, is the only satisfactory program for the patient who wishes to avoid crippling and fatal complications.

It has been our experience that most patients suffering from strictures fail to heed the early symptoms, as a diminishing of the urinary stream, and only seek help when compelled to by such complications as acute retention, cystitis, peri-urethral abscess, extravasation of urine, etc. Furthermore, when these conditions have been treated, and the patient is well on the way to a cure, almost invariably he takes matters into his own hands and disappears, reporting in a year or two in a worse condition than before.

The patient with acquired stricture is, as a rule, a coward when it comes to standing pain. Sometimes, I will admit, because of bad treatment, but usually just naturally so. I have seldom seen one who will not begin to "carry on" as soon as he sees a sound, and who does not quit treatment long before he is advised to, preferring temporary relief to further dilatation.

Any stricture that will admit a filaform can be dilated without the use of any interurethral surgery. As the authors say, after cystotomy often a supposedly impassable stricture will admit a filaform; therefore we make it a rule to drain the bladder suprapubically in difficult cases, only attempting an external urethrotomy as a last resort.

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Doctor Parker (Closing).—Doctor Kreutzmann emphasizes the necessity of early cystotomy, following acute trauma to the urethra, male and female. Retrograding a catheter is sometimes indicated, but after a cystotomy has been performed, a "hands off" policy proves to be the best procedure in a large percentage of cases.

We recall one unusual case of severe pelvic injury where cystotomy was not done immediately in a male patient. Drainage of the bladder through an indwelling catheter resulted in finding the tip of the catheter in the left cotyloid cavity, due to a complete dislocation of the head of the femur. Incidentally, it may be mentioned that this condition was caused by a collision of an automobile and a switch engine.

Female urethral strictures other than traumatic seem to be confined to the meatal orifice. The element of spasm referred from the urogenital tract, pelvic pathology, lower colon and rectal pathology, always play a great part in changes that occur at the meatus. Once a change occurs in normal acidity of the vaginal secretions, there is a continuous irritation of the urethral orifice. As the decades of life progress, such changes of constriction, irritability, frequency, caruncles, and even to carcinoma, become more frequent.

It is our belief that the majority of the developments of such unfortunate entities are equally due to the above-mentioned pathology, plus false modesty on the part of the women in the third to the fifth decade of life.

Thorough examination, elimination of etiology, will be a great step toward the relief of a great class of women who suffer in silence. A simple posterior meatotomy with a small electric cautery has given many of these patients a future life of comfort. Surgically, a well-trained man can work with impunity on the female urethra so long as he has the proper respect for the vesical sphincter muscle.

MUSSEL POISONING*

By Hermann Sommer
and
Karl F. Meyer †
San Francisco

THE paralytic form of shellfish poisoning has been recognized as a distinct clinical entity for over a century.[1] It is to be distinguished from the allergic type, which affects only the people who are hypersensitive to the particular sea food, and it differs distinctly from the gastro-intestinal form, which is caused by spoilage of the mussels or pollution in the water. The symptoms of paralytic mussel poisoning are due solely to a neuropoison and consist of a tingling sensation in the extremities, followed by numbness, and in severe cases by complete paralysis and death within a few hours.

EPIDEMIOLOGICAL RECORDS

Although the malady has long been known, its cause is still veiled in darkness. One reason for this, undoubtedly, is the scarcity of its occurrence. In the European literature of the last one hundred years only about fifteen outbreaks have been recorded, with a total of some 120 cases and twenty-four deaths. Since all the mussels involved came from limited areas, such as estuaries or harbors, the assumption was natural that local factors, and probably land drainage, had something to do with the formation of the poison.

On the other hand, the recent outbreaks in California have afforded ample opportunities to gain a broader viewpoint and to add to the knowledge of this matter. The most extensive outbreak of mussel poisoning occurred near San Francisco in 1927, with 102 cases and six deaths. Others followed in 1929, 1932, 1933, and 1934, so that

* From the George Williams Hooper Foundation, University of California, San Francisco.
Read at the annual meeting of the American Public Health Association at Pasadena, September 3, 1934.

† Coworkers of the Experimental Part: R. Stohler, H. Mueller and W. F. Whedon.

TABLE 1.—*Epidemiology of Mussel Poisoning on the Pacific Coast, 1927-1934*

Area	1927	1928	1929	1930	1931	1932	1933	1934	Total
Central California	102 (6)	....	62 (4)*	2	....	40 (1)†	7	....	213 (11)
Northern California and Oregon	....	....	....	....	....	....	15 (1)	....	15 (1)
Alaska	....	....	....	....	....	....	....	12 (2)	12 (2)
Total	102 (6)	....	62 (4)	2	....	40 (1)	22 (1)	12 (2)	240 (14)

* Including six (three) cases of clam poisoning.
† Including three cases of clam poisoning.
Number of deaths in parentheses.

at present some 240 cases, with fourteen deaths, are on record. They all occurred between June and August, and resulted from mussels gathered between the Monterey peninsula and Fort Bragg, with a smaller outbreak in September, 1933, in the area between Crescent City, California, and Coos Bay, Oregon. Quite recently a report from Juneau, Alaska, indicates that several cases occurred, with two fatalities, in that neighborhood in July, 1934. All the mussels involved were freshly gathered along the open ocean shore, remote from stagnant or polluted waters, and were consumed fresh. The mussels having to do with one outbreak came from a coast line of over one hundred miles. These epidemiological records alone would demonstrate that any local factors or land drainage could not have been involved, but that mussel poisoning was more likely a marine phenomenon. (Table 1.)

PERIODIC LABORATORY TESTS

These contentions were fully substantiated and considerably extended through laboratory examinations started in 1927 and carried on to this date. One of the results is a poison curve for mussels from the vicinity of San Francisco, extending over a period of some seven years. As indicated in Figure 1, every year during the summer months the toxicity of the mussels rises to a peak, varying in intensity from year to year and making its reappearance some time between June and September. During some years the peak will reach the danger line; in others it will not. A comparison of the epidemiological data and the poison curve indicates a close correlation between the number of cases and the degree of toxicity of the mussels. This may be taken as a proof that the laboratory test, consisting of the intraperitoneal injection of a mussel extract into mice, gives an accurate measure of the toxicity of the mussels

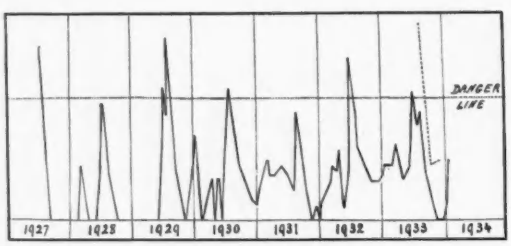

Fig. 1.—Toxicity of mussels near San Francisco.
(.....Northern California–Oregon.)

for humans. That the number of cases in the neighborhood of San Francisco has been steadily falling off is no sign of a decrease in toxicity, but indicates a more cautious attitude of the population in regard to the consumption of these shellfish. A second rise of lower intensity during the early spring months will be noticed. Furthermore, the decisive drop in toxicity to a minimum in late fall is noteworthy. At that time the poison may disappear entirely, or it may persist at a low level until the early spring of the following year. There are two phenomena, then, which need explanation: (*a*) the almost constant presence of minimal amounts of poison; (*b*) the strong increase in summer time. Both these findings are abnormal, since control mussels from La Jolla, San Diego, have never shown either of these characteristics. It is interesting to note, however, that poisonous mussels have been found not only along the coast from Monterey, California, to Coos Bay, Oregon, but also in samples received last year from Puget Sound, Washington.

SOURCE OF POISON

That shellfish poisoning is, indeed, a marine phenomenon was proved by further laboratory studies, together with field observations. It was found that mussels gathered at the lowest possible level are generally more poisonous than those growing higher up on the rocks. This disproves the popular belief that exposure to the heat of the sun is responsible for the production of the poison. A comparison of the various kinds of clams points in the same direction. It should be recalled that in August, 1929, three persons died from the consumption of Washington clams (Saxidomus nuttallii), gathered north of San Francisco. Tests showed that, of the dozen varieties of edible clams in this area, the most dangerous are the Washington and Horseneck clams, or those which receive the largest amount of fresh ocean water; while oysters and soft-shell clams (Mya arenaria), or those which grow in the quiet bay waters at a distance from the open ocean, are entirely harmless. This fact strongly suggests that the poison factor makes its appearance with the water. That the poison itself also disappears with the water is proved by the fact that poisonous mussels kept in the laboratory give off their toxin into the water, and lose one-half of their toxicity in about ten days. This decrease in toxicity is also noticeable if the mussels are kept in

a dry state, again refuting the argument that the harmful shellfish may have spoiled previous to consumption.

ADSORPTION OF MUSSEL POISON ON SAND

Attempts to demonstrate the poison itself in the water have long been unsuccessful. A better knowledge of its chemical characteristics finally helped to overcome the difficulty.[2] It was found that the poison may readily be removed from an aqueous solution by permutit. The fact that this synthetic silicate takes up only basic, organic as well as inorganic substances, proves definitely that the poison is of basic nature. This property was also of great help in the isolation of the substance from the water. Since the food of the mussel, the plankton, has long been under suspicion, large amounts of it were collected by filtration through plankton nets. The filter residue not only consists of plankton, but also of a large amount of microscopic sand, marine bacteria and detritus. Subsequently it was found that the sand contains a component which acts in a manner analogous to permutit, and which will take up the poison whenever it is in contact with its aqueous solution. It was natural, then, that the small amount of poison finally demonstrated in the water, *i. e.*, about a lethal mouse dose per bucket, was found adsorbed on the sand. Where it originally came from is still a matter of conjecture; it may have been contained in the plankton, or it may have been excreted by near-by mussels. What practical importance the floating sand may have as a carrier of the poison remains for further investigations.

PLANKTON COUNTS

Another possible approach to the study of the plankton in relation to the poison is, of course, the statistical method. Plankton counts, especially a detailed classification of all dinoflagellates, carried on for nearly three years, tend to show that several species of the genus Gonyaulax occur most frequently, and often in large numbers, just before and during the poison seasons. Besides, a physiological change in these organisms seems to occur frequently at about the same time, manifesting itself by a more intense pigmentation. While the ratio of the number of Gonyaulax to the degree of toxicity is by no means constant, it is not unlikely that a detailed study of these and other peridinials occurring at times in large numbers might yield interesting results.

DISTINCTION BETWEEN POISONOUS AND NORMAL MUSSELS

In this connection it should be recorded that during the poison period mussels are usually found with full intestinal tracts and enlarged digestive glands. This is of frequent, but by no means constant occurrence. In fact, there is not one characteristic which may be used as an absolutely sure distinguishing feature between normal and harmful bivalves. The general reactivity of the mussels, their respiratory quotient, the histological picture, the bacterial flora and protozoan fauna are some of the characteristics which have been studied and found more or less identical in the two groups of mussels. Unusual appearances along the ocean shore, like phosphorescence or "red water," have often been observed during the toxic season, but they cannot be relied upon as warning signals. The poison time falls in the summer months, when marine life is most intense and unusual phenomena are apt to make their appearance.

TOXICITY OF SAND CRABS

One of the unusual occurrences which was noticed for several years during the peak of the poison curve was the pronounced mortality of sand crabs. Subsequent investigation proved that these crustaceans are very nearly of the same toxicity as the mussels of the same locality at the same time.[3] They may be used, therefore, as test animals when mussels are not readily available. Although both the bivalves and the sand crabs are plankton feeders, the latter show some significant differences in their response to the substance. Sand crabs, with full intestinal canals, are as much as ten times more poisonous than those with empty digestive organs, indicating a rapid excretion of the poison. Furthermore, the crabs seem to be affected by some pathological condition which manifests itself in brown, melanin-like spots, around the joints of their legs. A detailed investigation of these conditions should be expected to help considerably in the elucidation of the problem.

With the help of the sand crabs, the widely held notion that the spawning of the shellfish is in any way involved in this problem may be readily disproved. The poison periods for the crabs and the mussels coincide, while their spawning seasons vary considerably. The sand crabs spawn mostly during the summer, while the mussels deposit their sex products in greatest numbers during the fall months, when the toxicity has subsided.

POTENCY OF MUSSEL POISON

It is strange that mollusks of such an intense toxicity that half a dozen of them are sufficient to kill a grown person should not show any outward signs of their poison. The explanation is that they contain a very small amount of an extremely toxic substance. Chemical studies have proved this. The purest preparations of poison so far obtained are lethal to mice in doses approaching one-millionth of a gram, on intraperitoneal injection. It is more active than any known chemical poison. Only the antigenic toxins of some plants and bacteria are more potent. In its action it resembles some of the most potent alkaloids. It acts quickly or not at all, and is rapidly excreted. It is not destroyed by boiling and not counteracted by any known drug.

PREVENTION OF SHELLFISH POISONING

Guarding against the poisoning is rather difficult. The best preventive method is education of the people in the collection and consumption of shellfish. The old saying that shellfish should be avoided during the months without *r* is

well founded, and September and October ought to be added also. Since practically all the poison is concentrated in the digestive gland of the shellfish, this organ should be strictly avoided. The broth, which naturally contains a good deal of the harmful substance, should also be discarded, at least during the summer months. It is doubtful whether any accidents would occur, even during the poison season, if only the light meat were consumed. A German investigator in 1885,[4] and recently a coworker in this laboratory,[5] have proposed that mussels be boiled for twenty minutes with the addition of sodium bicarbonate, which destroys most of the poison. This method is to be highly recommended from a chemical standpoint, less so from a culinary point of view. In California a seasonal quarantine on the sale of mussels, based on the present studies, has been found most expedient and undoubtedly has helped greatly in keeping the number of poison cases down to a minimum.

COMPARISON WITH SIMILAR POISONINGS

Mussel poisoning in itself would hardly warrant the time and energy spent in investigation of this sort were it not that a number of marine poisonings may be closely related to this problem in one or another of its aspects. They all have in common one characteristic: they are capricious in their appearance, and elusive. Fugu poisoning is caused principally in Japan by the consumption of the liver and sex products of Tetroden fish. It resembles mussel poisoning in that the active substance, although a sex poison, can hardly be distinguished chemically or toxicologically from the mussel toxin. The fish poison of the subtropical American waters, Ciguatera, is also of rare and elusive occurrence. The Haff disease, limited to a small number of localities of northern Germany, again made its appearance, after a lapse of several years, during 1933. It also occurs during the summer months exclusively and is caused by the consumption of eel and similar fish from the brackish waters of the Haff lagoons near Koenigsberg. Whether the explanation given at present by the German workers is correct, namely, that the sewage from the lumber and paper mills is to blame, remains to be seen. Last, but not least, the water-bloom poisoning, which has again been reported in recent years, especially from the lakes of Minnesota, must be mentioned, although it is of fresh-water origin. Cattle and other domestic animals may die in less than an hour after drinking from lakes which in summer are covered with the growth of blue-green algae. Here again an exceedingly potent substance, which is apparently liberated by some microörganism in the water, is to blame. Fitch, Gortner, and co-workers[6] have recently been able to demonstrate the poison in solution in the water.

CONCLUSIONS

Although the results of these studies are very incomplete, so far as the origin of this strange poisoning is concerned, the following conclusions seem justified. Mussel poisoning is definitely of marine origin. It has occurred for centuries, in the waters of the northern temperate zone, and it will undoubtedly occur again. There is nothing that can be done about it other than to study its peculiarities and guard against its effects. It is of rare occurrence, and experiences gained during the life of one generation have usually been forgotten by the next. It is hoped that the results of these studies will have thrown at least a little light on this interesting field of marine toxicology.

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SIGHT-SAVING CLASSES*

By FRANK H. RODIN, M. D.
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DISCUSSION *by Frederick C. Cordes, M.D., San Francisco; W. Morton Gardner, M.D., Los Angeles; George H. Kress, M.D., Los Angeles.*

THE majority of the medical profession, including many eye physicians, are not aware of the purpose of sight-saving classes, although they have been established in the United States since 1913. At present, there are over four hundred and thirty such classes, with an enrollment of over six thousand children.

Sight-saving classes are primarily for children whose vision is so impaired that they are unable to be educated in the regular classrooms, or their training is accomplished at the expense of their already limited vision. Children who are blind are educated, of course, in the schools for the blind.

CHILDREN ELIGIBLE FOR SIGHT-SAVING CLASSES

The children eligible for such classes are usually those whose vision is between 20 and 70 per cent in the better eye (between 20/200 and 26/60 vision, by Snellen's chart measurement); children who have a high myopia, where the myopia is over six diopters, or where there is a rapid progress of the myopia; or any child whose vision is such that he is unable to be properly instructed in the ordinary grade.

Under a specially trained teacher, a sight-saving class is set apart in the regular school building. Such a room should have a good eastern exposure to give the maximum of light with the minimum of glare. It should be equipped with special artificial light to be used on dark days. Large-sized type books are used. Slightly rough and unglazed Manila paper is employed for writing, and the

* From the Bureau of Child Hygiene, San Francisco Department of Public Health. J. C. Geiger, M.D., Director of Public Health.

pencils have soft, thick, heavy lead. The children in the fifth grade are taught to use the typewriter by the touch system. Oral teaching is done as much as possible. The pupils recite all oral work in the ordinary classes, but the written work is done in the special class, with the special sight-saving tools, under the guidance of the teacher.

These classes are usually limited to a small group of children, from twelve to fifteen in number.

A description of the children attending such a sight-saving class in an elementary school will illustrate its purpose and its value.

The following histories are taken from the eye physicians' reports which are requested for each child.

HISTORIES OF CHILDREN IN AN ELEMENTARY SIGHT-SAVING CLASS

1. Nystagmus. G. M., boy, age six years, has been attending sight-saving class for a year. Vision: right eye, 70 per cent; left, 65 per cent.

* * *

2. Degenerative changes of the maculas. Mixed astigmatism. Left eye: Convergent strabismus. C. E., boy, age eight years, attending class two months. Vision: right eye, 33 per cent; left, 4 per cent.

* * *

3. Congenital cataracts. Operations. W. D., boy, age eight years, attending class one year. Vision: right eye, 50 per cent; left, 50 per cent.

Previous to his entrance to the sight-saving class he could do nothing in the regular grade. At present he is able to do the class work required for his age.

* * *

4. Microphthalmi. Malformation of the retinas. T. M., boy, age eight years, attending class three years. Vision: right eye, 10 per cent; left, 4 per cent.

It is remarkable what progress this boy has made since his entrance into the sight-saving class. His whole personality has changed, and he is doing the required work for his grade.

* * *

5. Compound hyperopic astigmatism. R. H., boy, age nine years, attending class six months. Vision: right eye, with + 3.00 sph. ⌒ + 2.50 cyl. axis 100° = 90 per cent; left, with + 3.00 sph. ⌒ + 2.50 cyl. axis 80° = 90 per cent.

This boy was unable to do much work in the regular classroom. He was constantly complaining of severe headaches and difficulty in reading for any length of time. Since attending the sight-saving class he is able to do his work with complete comfort.

* * *

6. Right eye: Nystagmus and myopia. Left: Congenital glaucoma. Iridectomy. Phthisis bulbi. M. D., girl, age nine years, attending class two years. Vision: right eye, with — 6.00 sph. = 20 per cent; left, blind.

Since attending the sight-saving class, she is learning to read and add numbers. She could do nothing in the regular class.

* * *

7. Compound hyperopic astigmatism. B. F., boy, age nine years, attending class six months. Vision: right eye, with + 4.00 sph. ⌒ + .50 cyl. axis 105° = 20 per cent; left, + 3.50 sph. ⌒ + .75 cyl. axis 75° = 75 per cent.

At the regular school, his work had been very poor; but since entering the special class there has been marked improvement.

8. Right eye: Congenital amblyopia. Left: Congenital cataract. Operation: Blindness. C. E., girl, age nine years, has been attending class two months. Vision: right eye, 50 per cent; left, blind.

Her school work was poor when she attended the regular class, and she was absent most of the time because she could not see well. At present she is very happy and is doing good work.

* * *

9. Congenital cataracts. Operations. Microcorneas. B. S., girl, age nine years, attending class nine months. Vision: right eye, 10 per cent; left, 15 per cent.

This child had never been in school, because of poor vision, before entering the sight-saving class. She is now doing third-grade work.

* * *

10. Progressive myopia. M. F., girl, age ten years, attending class one year. Vision: right eye, recognition of fingers at ten feet, with — 5.00 sph. = 90 per cent; left, recognition of fingers at ten feet, with — 5.50 sph. = 90 per cent.

This girl's myopia progressed considerably during the last two years.

* * *

11. Retinochoroiditis. Left eye: Internal strabismus. C. L., girl, age ten years, attending class two years. Vision: right eye, recognition of hand movements, with her glasses = 15 per cent; left, recognition of hand movements, no improvement with her glasses.

* * *

12. Chronic iridocyclitis: Secondary cataracts. O. M., boy, age eleven years, attending class three years. Vision: right eye, 33 per cent; left, recognition of fingers at one foot. The irises are atrophic and adherent to secondary membranes in the pupillary areas.

In spite of his poor vision, he is doing excellent work.

* * *

13. Mixed astigmatism. R. O., boy, age eleven years, attending class eight months. Vision: right eye, with + 1.00 sph. ⌒ — 4.00 cyl. axis 45° = 50 per cent; left, + 1.00 sph. ⌒ — 4.00 cyl. axis 50° = 75 per cent.

* * *

14. Compound hyperopic astigmatism. M. N., girl, age eleven years, attending class four months. Vision: right eye, with + 3.00 sph. ⌒ + 3.00 cyl. axis 90° = 20 per cent; left, + 4.00 sph. ⌒ + 2.00 cyl. axis 90° = 20 per cent.

She was unable to do any work in the regular grade, due to her poor vision.

* * *

15. Chronic iridocyclitis: Complicated cataracts. H. M., girl, age twelve years, attending class four years. Vision: right eye, 63 per cent; left, 40 per cent. The corneas are hazy, due to fine opacities.

This girl was a truant case: her reason for not attending school was that she did not see well. Since attending the sight-saving class, she has been doing good work and is ready to enter Junior High School.

* * *

16. Compound hyperopic astigmatism. W. H., boy, age twelve years, attending class six months. Vision: right eye, with + 3.00 sph. ⌒ + 3.50 cyl. axis 100° = 75 per cent; left, with + 3.00 sph. ⌒ + 3.50 cyl. axis 80° = 75 per cent.

The above boy and the one reported in Case 5 are brothers. Both complained that while attending regular classes they were subject to severe headaches, especially when trying to do any reading. Since attending the sight-saving class, they are free of complaints and are capable of doing with comfort the

school work required of them. Both parents of the boy and their families have high refractive errors with poor visual acuity.

* * *

17. Congenital dislocation of lenses. Central choroiditis. L. L., boy, age twelve years, attending school three years. Vision: right eye, 80 per cent; left, 80 per cent.

* * *

18. Hyperopic astigmatism. W. C., boy, age thirteen years, attending school four years. Vision: right eye, 20 per cent, with + 1.25 sph. ⊃ + 5.75 cyl. axis 90° = 90 per cent; left, same as the right.

This boy could do very little work in the regular class and was a discipline problem. He used to complain of a great deal of eye discomfort. Since attending sight-saving class his work is fair and his deportment has improved.

* * *

19. Compound hyperopic astigmatism. Right eye: ptosis upper eyelid. Internal strabismus. H. L., boy, age fourteen years, attending class seven years. Vision: right eye, with + 1.00 sph. ⊃ + 3.00 cyl. axis 80° = 50 per cent; left, with 1.00 sph. ⊃ + 3.00 cyl. axis 80° = 75 per cent.

The boy's mental age is nine years six months (Stanford-Binet test) and his intelligence quotient is seventy-one. He is a borderline case, closely approximating mental deficiency. He was sent to the sight-saving class because it was thought that his poor vision might be a factor in his poor class work. There has been no improvement in his mentality. However, he has gained more than he would have acquired in a regular classroom, and he is to enter Junior High School next term.

COMMENT

This special class has an enrollment of nineteen children, rather a large number for such a class. This is partly due to the fact that nine children enrolled during the last year.

There are only two children with high myopia present in the class, which is much less than the number usually found in a sight-saving class. About one-third of the children enrolled in a sight-saving class have high myopia.

In the Junior High School sight-saving class of this city, where the enrollment is fifteen, the number of children with high myopia is seven.

It is evident from the histories of the children enrolled in the sight-saving class that, with their various visual handicaps, they can receive very little training while attending the regular classes. In a sight-saving class, on the other hand, these children have the same opportunity for education as children with normal vision.

The children are recommended for entrance to a sight-saving class either by their attending eye physician or through the inspection conducted by school medical examiners.

Apparently, very few of the eye physicians and general practitioners realize the opportunity for the education of a visually handicapped child, as very few of these children have been recommended by them.

The majority of the children enrolled have been found by the medical examiners, or by the school teachers who observed, that the child had poor vision and requested an examination of the eyes by a school medical examiner.

SUMMARY

1. Sight-saving classes are for children who are visually handicapped.

2. The histories of nineteen children attending a sight-saving class are given.

3. None of these children are capable of receiving the usual school education in the regular classrooms.

4. The medical profession, especially the eye physicians, should consider the hinderments to education of the children whom they find to have poor vision; and children whose vision is so poor that they are unable to be instructed in the regular classrooms should be recommended for admission to a sight-saving class.

5. It has been estimated that in the United States one child out of five hundred (or a thousand) has a visual handicap, and should attend a sight-saving class.

490 Post Street.

DISCUSSION

FREDERICK C. CORDES, M. D. (384 Post Street, San Francisco).—Doctor Rodin's paper is timely in that it again calls to the attention of the medical profession the existence of sight-saving classes. He has been interested in this work for a number of years and has done a great deal to establish these classes in San Francisco on their present high plane.

These children with poor vision are a definite problem. Because of their visual handicap, it is impossible for them to keep up with the normal school work of children of their own age. In attempting to do this they are often looked upon as dull children and are frequently "guyed" by their classmates. Thus, such a child is frequently very unhappy, and early develops an inferiority complex.

In these special sight-saving classes, such children are given training commensurate with their vision. Before they are enrolled, a complete report of the eye condition is obtained from the ophthalmologist. His advice as to the amount of eye work permitted is sought and his suggestion is carefully followed. Therefore, these children are cared for as individuals and not as a group. Upon completion of their school work they are able to be self-supporting individuals rather than dependents. They are not to be confused with the blind, who are unable to do many things accomplished by this group having defective eyesight.

As Doctor Rodin points out, either most eye physicians are ignorant of this work or do not take the necessary time to explain its purpose to the parents of such children. A short time ago I saw a boy of six who had a marked congenital nystagmus with amblyopia and vision of 20/200 in each eye, with correction. At the completion of the examination, I explained the situation to the mother and talked to her about the conservation-of-vision class. She was delighted to know that something could be done. The boy's twin sister did not have this defect, and the mother had been worried some time, realizing that he would be unable to keep up with her. This patient had been seen by three oculists, none of whom mentioned the possibility of special training for this child with defective vision.

As stated above, I feel that Doctor Rodin's paper is very timely, and it is to be hoped it will call to the attention of the medical profession this very important and often neglected phase of our work.

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W. MORTON GARDNER, M. D. (5514 Wilshire Boulevard, Los Angeles). — In discussing Doctor Rodin's paper concerning sight-saving classes, I would simply emphasize certain points.

To begin with, Doctor Rodin's comment concerning the attitude of physicians, even oculists, toward sight-saving classes is timely. We ophthalmologists are prone to be jealous of our results, and are reluctant to admit that we have not afforded our patients 6/6 vision. We proudly call the attention of the parent to a gain of at least from 6/60 to 6/30, forgetting that 6/30 vision still leaves the child educationally handicapped. Again, believing that the use of the eye will improve its visual acuity, some advise regular class work in school, not realizing that our modern public school curriculum spells *excessive use* of the eyes, or *strain* to the child with defective vision.

We do not ask the athlete to begin with the impossible to train to do his best.

Placing a child in a sight-saving class does not diminish his vision. It does diminish the *abuse* of his vision. He obtains his education with greater ease and does not mortgage his future vision, but retains it for later industrial use and enjoyment.

It may be that we of today are too paternalistic. There is a question whether we gain socially or economically in trying to educate the moron. But the nineteen cases reported by Doctor Rodin are representative of hundreds of children who have demonstrated that special attention to the physically handicapped, even the subnormal mentally (No. 19) has unquestioned social advantages. Moreover, we should be careful in classifying as subnormal mentally a child who does not measure up by an intelligent quotient test and who, at the same time, is handicapped physically. As Dr. Don Flagg has so frequently pointed out it may be a case of "mental retardation from deprivation of a special sense," which should solicit our sympathetic assistance, even though it may injure our professional pride that our patient has to attend a sight-saving class.

It is a pathetic picture—the visually handicapped child left in the regular grades to fight his way against terrific odds; yet how quickly we protest if an athlete is handicapped by the slightest injustice.

One of the crying needs of the day, therefore, is greater sight-saving class facilities. With an enrollment of 200,000 in the first eight grades of our Los Angeles city schools, according to estimates there are probably four hundred children in these grades with vision so poor as to require special aid in order to obtain their education in a reasonable time, if at all. We have, however, less than one hundred in our elementary grades assigned to sight-saving classes, and about thirty in junior high grades. Probably other cities have a similar deficiency. Greater concern for the education of their patients on the part of oculists and better coöperation with the school physician, who well appreciates these facts, might mitigate this wrong.

I commend Doctor Rodin for his timely presentation of the facts with typical cases as proof.

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George H. Kress, M.D. (945 Roosevelt Building, Los Angeles).—Of the twenty-five million school children in our country, about three million have visual defects of sufficient amount to become, if not corrected, handicaps during and after school years. Children with deficient vision of a degree sufficient to place them in what is known as the partially-seeing group should be sent to sight-saving classes. Doctor Rodin has indicated the types and degrees of visual deficiencies which give the indications for transferring children from ordinary classrooms to the sight-saving classes. A perusal of the case reports which he submits makes understandable the reasons why society, because of the physical and emotional factors involved, is obligated to aid such children. The care of those thus embarrassed is a problem worthy of the serious attention of physicians, because the future happiness of these future citizens is determined, to a large extent, by the means taken to educate them during their school years. Children with such visual defects are handicapped not only in ordinary school work and in play, but often in their homes; and so much so that they can easily develop inferiority complexes, and occasionally, through egotism in the possession of an unusual physical deformity, superiority or extrovert complexes.

It is heartening to know that almost five hundred sight-saving classes are maintained today in about 150 different communities. It is true that this provides for only a small percentage of the fifty thousand or so children in the United States who need this special sight-saving training, but it is a real and much needed beginning. It is gratifying, also, to know that San Francisco, Los Angeles, and other cities are among the progressive centers which have inauguraed such training in California. We suggest that California communities in need of sight-saving classes ask Doctor Rodin to aid them in the solution of their problems.

ENCEPHALOGRAPHY IN CHILDREN*

By F. G. Lindemulder, M. D.
San Diego

Discussion *by Howard Fleming, M.D., San Francisco; E. B. Shaw, M.D., San Francisco; Mark Albert Glaser, M.D., Los Angeles.*

It has been just during the past few years that encephalography has become a common adjunct of the neurological examination. Only recently has its use been extended appreciably to the realm of pediatrics. Its value lies chiefly in the diagnostic field, although it has been found to have a therapeutic value as well. The encephalogram checks the clinical diagnosis and is an aid in demonstrating to the physician, as well as to the relatives of the patient, the organic change that has taken place in the brain. Therapeutically, the procedure may have a favorable effect in cases of concussion headache, traumatic encephalitis, and the epilepsies, especially those due to encephalitis.

INDICATIONS AND CONTRA-INDICATIONS

Encephalography is not a procedure to be recommended lightly without regard to the type of case. It is dangerous in cases of tumor of the posterior fossa, unless the fluid is drawn off slowly and the air injected at intervals following the removal of small quantities of cerebrospinal fluid. It is positively contraindicated, in my opinion, in the presence of an infection either in the blood stream or in some focus near the cranial cavity. Under such circumstances, I have seen the removal of spinal fluid followed by the development of a meningitis which, I feel sure, would not have occurred if the infection had not, so to speak, been drawn into the central nervous system. Aside from these two considerations, however, it may be looked upon as a harmless procedure.

ANESTHETIC

I prefer an inhalation anesthetic for making encephalograms in children, because of the difficulty in obtaining coöperation, and the possibility that the child may move and break the lumbar puncture needle. It has been my custom, there-

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* From the Rees-Stealy Clinic.

Read before the Pediatric Section of the California Medical Association at the sixty-third annual session, Riverside, April 30 to May 3, 1934.

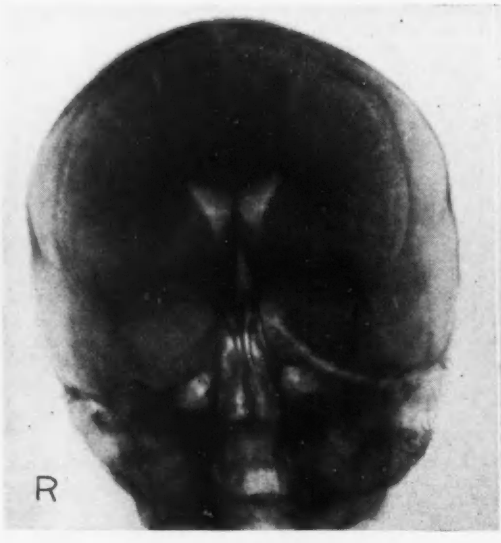

Fig. 1

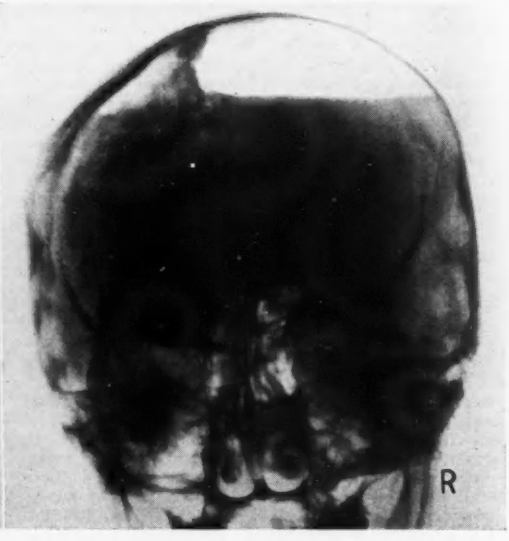

Fig. 2

Fig. 1.—Subarachoid space over right cerebral cortex demonstrates little if any air as compared with the left. The ventricular system is of normal size and position. Case of adhesive arachnoiditis following subarachnoid hemorrhage.

Fig. 2.—External hydrocephalus resulting from birth injury. The ventricular system was not visualized.

fore, to use ether anesthesia. Others, however, have had good results with barbituric acid preparations, avertin, morphia, etc.

WITHDRAWAL OF THE CEREBROSPINAL FLUID

In withdrawing the cerebrospinal fluid and injecting the air, it is best to replace each five cubic centimeters of fluid removed with the same amount of air. The total amount of air injected equals the total amount of fluid removed; and this varies with the individual patient and the type of brain disturbance. I feel that 150 cubic centimeters of air are sufficient to make an accurate diagnosis; occasionally, in cases in which it was possible to inject only 60 cubic centimeters of air, this amount was found, surprisingly, to be sufficient for diagnosis.

PROCEDURE IN TAKING THE ENCEPHALOGRAM

For taking the encephalogram, a special chair such as has been described by Camp and Waggoner, and others, or an operating table may be used. At the beginning of the procedure the patient may lie on his side; but it is soon necessary to place him in a sitting posture in order to obtain sufficient flow of the cerebrospinal fluid. The patient then remains in the upright position until after the roentgenograms are taken. This prevents a shift of air, which might cause difficulty in the interpretation of the films.

The encephalogram not only may show the location and size of the ventricles and cisterns, but also, since the air spreads over the cortex as well, may demonstrate the presence of cortical atrophy, subdural growths and hemorrhages. Therefore, the x-ray films should include at least anterior-posterior, posterior-anterior, and right and left stereo positions of the skull.

REPORT OF CASES

The following brief case reports illustrate the information that may be obtained from the encephalogram:

Case 1.—A child, aged four years, was brought to the hospital by the parents because of convulsions. The neurological and physical examinations failed to show any evidence of organic disease. The encephalogram (Fig. 1) disclosed that there was little, if any, air over the right cerebral cortex as compared with the left, whereas the ventricular system was of normal shape and position. This finding indicated that, at some time, the patient had probably had a subarachnoid hemorrhage, which resulted in an adhesive arachnoiditis. This arachnoiditis was probably causing enough irritation to produce the convulsive state.

* * *

Case 2.—A female patient, aged 24 years, had received a cerebral injury at the time of birth, which, when we saw the patient, was manifesting itself clinically as a left hemiplegia. The encephalogram (Fig. 2) showed no air in the ventricular system and a marked external hydrocephalus, particularly on the left.

* * *

Case 3.—The third case was that of a girl, 15 years of age, who, four weeks prior to the taking of the encephalogram, had had a basilar skull fracture. The patient complained of terrific headaches and was unable to talk. The roentgenograms (Figs. 3 and 4) demonstrated the ventricular system exceptionally well, but no air was seen over the cortex of the brain. This finding indicated a diffuse hemorrhage over the entire cerebral cortex, which occluded those subarachnoid spaces.

IN CONCLUSION

Encephalography marks a definite step forward in the progress of medicine. It is of value as an aid in diagnosis and prognosis, and it constitutes a form of therapy in certain selected cases of brain disturbance.

2001 Fourth Avenue.

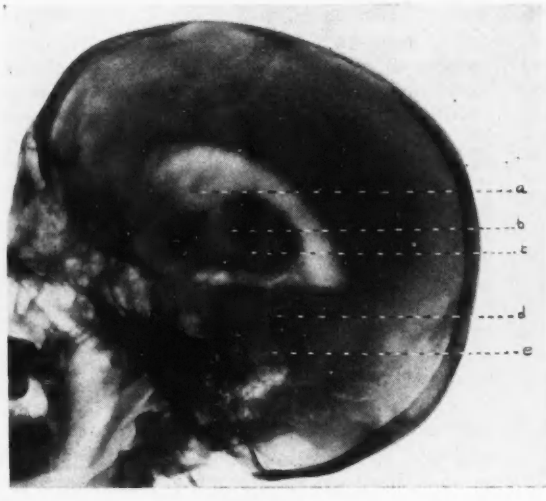

Fig. 3

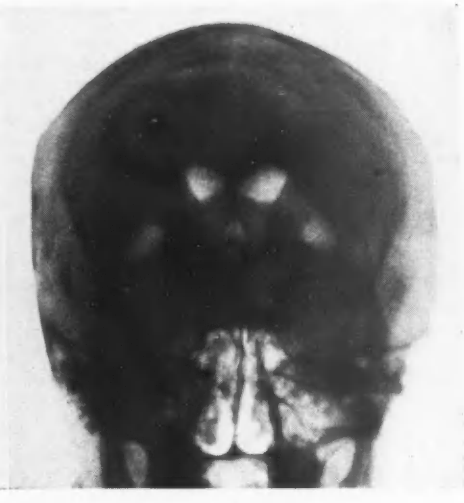

Fig. 4

Fig. 3.—An unusual demonstration of the ventricular system. No air is seen over the cortex of the brain. (a) Lateral ventricles; (b) Middle commissure; (c) Third ventricle; (d) Aqueduct of Sylvius; (e) Fourth ventricle.

Fig. 4.—PA view of Figure 3, showing no deviation of ventricular system and no filling of subarachnoid spaces over the cortex of the brain with air. This is a case of subarachnoid hemorrhage following basilar skull fracture.

DISCUSSION

HOWARD FLEMING, M. D. (384 Post Street, San Francisco).—Doctor Lindemulder's paper, emphasizing the value of encephalography as a diagnostic measure, is most timely. Visualization of the size, form, and position of the ventricle and subarachnoid spaces will often give valuable information as to the intracranial pathology. This is particularly true in patients suffering from convulsions. Only too frequently patients are treated for idiopathic epilepsy without proper investigation. Encephalograms often reveal unsuspected pathology in such cases.

The procedure is attended with a slight amount of risk. This is especially true in elderly patients with advanced arterial changes and in patients with signs of increased intracranial pressure. Symptoms or signs of the posterior fossa lesion are definite contraindications for encephalography. In these cases the introduction of air directly into the ventricle is the method of choice.

The technique of encephalography is not standardized. Most surgeons prefer to carry out the procedure with the patient anesthetized and in a sitting position. In our experience, the use of two needles in the lumbar spaces adds to the safety of the procedure, and gives a greater percentage of satisfactory results. Recently the use of gases other than air, as reported by Dr. Robert Aird, promises a marked improvement, particularly as to the reaction on the patient.

The interpretation of the films is the most important part of the test. Wide variations from normal offer no difficulty, but frequently the changes are slight. The most meticulous attention to detail must be used in taking the film, if error in diagnosis is to be avoided. Improper position of the head or misdirection of the ray will often eventuate in films that suggest pathology and may be most misleading.

Encephalography is a diagnostic help only and must be correlated with all other information to be obtained. Cases for its use must be selected carefully. Indiscriminate use of encephalography might very well serve to discredit this most valuable diagnostic aid.

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E. B. SHAW, M.D. (384 Post Street, San Francisco). Visualization of intracranial conditions is a valuable adjunct to the usual methods of anatomic diagnosis of the diseases of the central nervous system in childhood. Encephalography not only accomplishes visualization, but sometimes affords surprising therapeutic effects. It is of especial value in conditions involving cerebral birth accidents and congenital defects of brain development.

Despite the value of the method, the precautions and contraindications mentioned should be weightily regarded. The procedure is not intricate, but its employment, and particularly the management of its complications, requires a trained neurosurgical technique. The interpretation of results is not altogether simple, and training and experience are necessary lest artifacts be interpreted as true anatomical lesions.

This paper has been presented to pediatricians, and it behooves us to employ the method as indications arise. Few of us, however, possess the requisite training, or encounter a sufficient number of cases to enable us to perfect a technique of performance or the interpretation of results.

As a final word of caution, it might be proposed that encephalography be not regarded as a pediatric procedure, but should preferably be delegated by the pediatrician to those who have adequately perfected their methods, are sufficiently skilled in interpretation of results, and are prepared to carry out such further steps as are indicated or necessitated by this diagnostic procedure.

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MARK ALBERT GLASER, M. D. (727 West Seventh Street, Los Angeles).—Doctor Lindemulder has clearly emphasized the importance of encephalography as a diagnostic procedure. Furthermore, he has definitely stated that this method of diagnostic procedure is not without risk. The mortality in encephalography carried out in the proper hands is about one-quarter of one per cent. The encephalogram is not only of diagnostic value, but in certain cerebral cases is a valuable therapeutic adjunct.

Encephalography should not be looked upon as a terrifying procedure, and valuable information which can be obtained from such procedure should be a matter of common knowledge.

By the encephalogram we are able to visualize changes in the ventricles as to size and shape, and abnormalities in the subarachnoid space, such as adhesions or atrophic areas, may be observed. Therapeutically, convulsive states have been benefited;

post-traumatic headaches have been relieved and the adhesions from meningitis have been eliminated. Furthermore, convulsive states secondary to brain tumor have been accurately diagnosed, and in cases of birth trauma some prognosis as to the exact amount of damage, as well as the future of the child, can be arrived at. In other words, the procedure is definitely indicated in obscure neurological diseases wherein a clinical diagnosis cannot be accurately made or when brain tumor is suspected. This procedure has definite contraindications, as pointed out by Doctor Lindemulder; and in such cases wherein an outline of the brain is desired, ventriculogram is indicated.

I have enjoyed hearing Doctor Lindemulder's paper and I want to congratulate him on simplifying a subject which has heretofore been looked upon as technical, dangerous, and uninteresting.

RECONSTRUCTIVE PLASTIC AND ORAL SURGERY*

By ARTHUR E. SMITH, M. D.
Los Angeles

DISCUSSION *by William S. Kiskadden, M. D., Los Angeles; Francis L. Anton, M.D., Los Angeles; George Warren Pierce, M. D., San Francisco.*

THE recent economic crisis has brought to our attention an urgent demand for reconstructive surgery. Competition for a chance to start in the business world, more so to maintain a position therein, is so keen that one handicapped by a physical deformity must show a prodigious mentality to be considered. These unfortunate people are innocent victims of circumstance; who are often objects of pity and may even evoke the aversion of their friends. They are prone to become recluses and live somewhat like the marked introvert. They may not become efficient in even the most simple lines of endeavor, resulting in a condition which leads to the establishment of an inferiority complex. Why should we, as medical men, permit such a situation which can so easily be prevented by reconstructive plastic surgery!

There has been a definite trend in our modern civilization towards accentuating beauty in all forms of commercial industry, as is represented by architecture, municipal planning, automobile and aeroplane designing, and even in our personal stationery. This trend, whether or not admitted by the critic, certainly stands out as a definite fact. Employers show a marked tendency to select only those individuals who are personable as well as capable. We, in this community, are particularly confronted with countless demands for the correction of those defects which are magnified by the camera in one of our largest industries, the production of motion pictures. One can readily appreciate the personal economic value of the correction of a slight deformity which may bar chances for advancement in a chosen field. Defects should be corrected in the formative years, thus assuring better results from a cosmetic and psychological standpoint. Observations in the streets, the theatre or the schools evidence the truthfulness of this statement.

*Read before the General Surgery Section of the California Medical Association at the sixty-third annual session, Riverside, April 30 to May 3, 1934.

THE FIELD OF PLASTIC SURGERY

The field of plastic surgery which rightfully belongs to the medical profession has been invaded, not only by quacks and charlatans, but by unethical and ill-prepared practitioners as well. By means of unscrupulous and flagrant advertising, these people have placed themselves before the public eye as the ultimate need of anyone seeking beauty or health. This, coupled with the bad results of their "curative art," is exemplified by the fact that we have, in our court records, examples of people seeking redress for the often irreparable damage that they have done. Consequently, the public has a mistaken idea of plastic surgery, and a disrepute has been imposed on this specialty. It is the responsibility of organized medicine to educate the public to the real value and work of the ethical plastic surgeon who is respected by his colleagues.

Many have incorrectly considered plastic surgery to be entirely a development of the recent war. While the progress of reconstructive plastic surgery since that time has been great, literature reveals that successful plastic operations were accomplished centuries ago. Attention was called to this fact in a paper read before the American Surgical Association in 1925, by Dr. John Staige Davis, plastic surgeon at Johns Hopkins University. Tagliacozzi, in 1597, was the first to write a book on plastic procedures, but there were earlier reports of plastic surgery of the face by Benedictus in 1492. The technique as described by Tagliacozzi was forgotten until the eighteenth century, when it was enthusiastically revived by many surgeons who recognized the value of this specialized branch of general surgery.

INFLUENCE OF THE GREAT WAR ON PLASTIC SURGERY PROCEDURES

The volume of deformities resulting from the recent great war stimulated the establishment of many procedures of plastic surgery which previously were merely experimental. Among the methods of modern advancement, the writer desires to place special emphasis on the value of Gillies' tubed pedicle, the use of a modeling compound method in the application of the Thiersch-graft, the application of mechanical principles in splinting and moulding the tissues, and the cartilage transplant. Plastic surgery of the face and the tissues involving the oral cavity is one of the most difficult branches of surgery from the standpoint of cosmetic appearance and restoration of normal function, frequently in the presence of infection.

THE AUTOMOBILE A CAUSATIVE AGENT IN FACE DEFORMITIES

The automobile is possibly the greatest factor in producing deformities of the face, especially the nose and jaws. Present day sports, such as boxing, wrestling, football, basketball and swimming, often result in broken noses and jaws, torn and lacerated facial tissues, formation of cauliflower ears, all of which demand repair. Efficient

first-aid surgery does not in most cases produce the desired functional and cosmetic result. Plastic surgery is useful for the removal of scar tissue, especially following destructive action of second and third degree burns, which have produced an unpleasant appearance or impaired function. Reconstruction is needed for the removal of keloids, to correct an unsightly ectropion, or a facial deformity resulting from paralysis of the facial nerve. The restoration of normal functions to children afflicted with congenital cleft palate, and cleft lip, is a credit to plastic surgery. The successful accomplishments of restoration, transplantation and reconstruction of tissues have been so great during the past decade that the larger medical schools throughout the country have established departments of reconstructive plastic surgery.

FIELDS OF APPLICATION IN FACIAL DEFORMITIES

Destruction of facial contours caused by depressed fractures of the malar and superior maxillary bones may be restored to normal. Acquired and congenital deformities of the eyelids, with total or partial absence, are easily corrected. Abnormal inverted or everted eyelids, closure of the palpebral opening, drooping of the upper lid, and the presence of a fold of skin extending over the inner angles of the ocular openings, are some of the defects of natal origin which come to the surgeon's attention. Eyebrows can be replaced. Certain unsightly discolorations of the skin resulting from congenital lesions, or those acquired by tattooing, gunpowder and certain chemicals can easily be removed. Included in the field of plastic surgery are the reduction of hypertrophied lips; an ear may be restored or rebuilt by using a metal mould; protruding jaws reduced; reconstruction of secondary deformities produced by badly designed lip closure; restoration of philtrum, cupid's bow and vermilion border line; application of Thiersch-grafts on moulds for the restoration of buccal and labial oral sulci due to obliteration by scar tissue, thus making it possible for patient to wear a dental plate; alveolomerotomy, operation for reduction of upper edentulous jaw protrusion for dental prosthesis construction; for the removal of scar tissue causing a distorted socket and placing of new conjunctional fornices capable of carrying an artificial eye; the application of a Thiersch-graft on a thin mould in symblepharon; the rebuilding of an upper or lower lip; the closure of chronic ora-antral sinus; for skin grafting; following the removal of scars which prevent normal movement of joints caused by burns or extensive trauma; for the bony reconstruction of the lower jaw and the establishment of normal facial contour and profile of the soft tissues.

THE NOSE IS IMPORTANT AS A BASIS FOR GOOD APPEARANCE

We believe that the nose is the basis of good looks. Cosmetic indications for the correction of an awry or deformed nose must not be undervalued, and impaired breathing must be given great consideration. It is believed that trauma is the causative factor in at least 75 per cent of these cases. Injury may antedate the patient's memory, for the developing bone and cartilage in early childhood are very tender, and even a slight blow may produce displacement of the nasal bones or deviation of the nasal septum. Such abnormalities cause mouth breathing, which may result in irregular, unerupted or impacted teeth, the formation of abnormal dental arches and protruding jaws. Displaced, undeveloped nasal bones or an injured septum may continue to ossify at a vicious angle. Trauma to the nose in early childhood appears to cause less fibrous adhesions and exostoses than trauma in later life.

RECONSTRUCTIVE SURGERY IMPLIES INDIVIDUALIZATION

Reconstructive surgery requires skillful care. No two cases being similar, each must be studied individually and the technique for reconstruction must be carefully outlined and planned prior to operation, if efficient results are to be attained. Photographs of each patient should be taken and preoperative models made. The author has perfected a plastic compound for the making of the negative or mould, which has proven satisfactory because the most exacting detail is reproduced on the positive, or model. This compound is so light and free from irritating qualities that a face mask is taken with the patient's eyes open without producing the slightest irritation to the conjunctivae. It is neither cohesive nor adhesive, making possible its application and removal from eyebrows and lashes without producing discomfort. The positive, which is capable of recording the most minute detail contained on the negative or mould, is very hard, does not expand or contract, is flesh colored in appearance, and is not porous, making it ideal for actual color reproduction of lesions. The face mask or oral impression, if carefully made, will produce an accurate reproduction of the part to be operated. Such lesions as a scar, cleft lip, cleft palate, deformed ear, nose or jaw, can be accurately duplicated in model form. These models are valuable in planning the operation and in the construction of case splints and the outlining of flaps, and for the moulding and reshaping of tissues, in order to restore correct anatomic form, outline and function.

Not only are accurately made models and sharply detailed photographs important preoperative adjuncts, but they are also invaluable as permanent records. In addition, they afford a comparison between the preoperative condition and the results of reconstruction. Obviously, photographs should never be retouched, because the detailed results of the surgery would be camouflaged, and thereby, rendered unscientific.

EFFICIENT SURGICAL TECHNIQUE IMPLIES APPLICATION OF PROPER MECHANICAL PRINCIPLES

Success attained from plastic surgery is perhaps due equally to efficient surgical technique and the proper application of mechanics in construc-

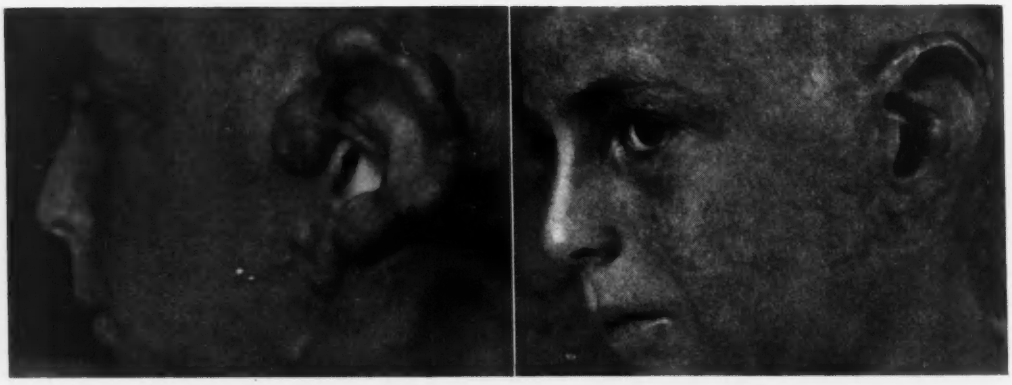

Fig. 1 Fig. 2

Fig. 1 (Case 1).—Excessive scarring of left ear and cheek resulting from third degree burns caused by ignited gasoline, followed by keloid formation. Cartilage was involved. The right ear and cheek also badly burned.

Fig. 2 (Case 1).—Illustrating the result obtained from reconstructive surgery followed by x-ray and radium therapy treatments.

tion of patterns and moulds, with the making of definite plans of the operation before the time of actual surgery. Accurate patterns may be constructed of thin rubber, if the operation is to be on the skin surface; of metal if the operation involves transplantation of cartilage or bone. These models, which are sterilized and used at the operating table, should be carefully prepared in order that the cartilage, bone or soft tissues can be properly shaped before being transplanted to the operative field.

The greatest enemies to the plastic surgeon are sepsis, formation of keloids, and inadequate blood supply. A necessity in keeping scars to a minimum is the proper selection of suture material, and the placing of the sutures with accurate coaptation of the incised edges with a minimum of tension.

The day has passed for the injection of paraffin, insertion of ivory, celluloid or other foreign materials, for the partial restoration of a lost part. The constant irritation of these foreign bodies may cause sloughing of the normal tissues, or may lead to cancer. The injection of paraffin is the sheet anchor of the "quack" facial specialist.

An important factor of plastic surgery is the realization of surgical limitation. It is better to do a series of plastic operations, giving nature time to do her part between each procedure, than to try to accomplish too much at one operation. The rebuilding of human tissues requires patience, painstaking care and attention to detail.

REPORT OF CASES

The following six case reports have been of particular interest because of the diversity of lesion and application of some of the principles mentioned above.

* * *

Case 1.—Male, aged eight years. When this patient was four years old he received a third-degree burn, caused by his father's cigarette igniting a bucket of gasoline. The healing of the burned areas about the ears, cheeks, lips and neck was rapidly followed by keloid formation, which enlarged to such an extent that the child's appearance was most unsightly. The keloid formation was difficult to combat. Prior to and following surgery, x-ray treatments proved inadequate and the use of radium was substituted with adequate success. (See Figs. 1 and 2.)

* * *

Case 2.—Female, aged sixteen years. This patient is one of twin girls who, the mother states, were so identical that she had difficulty in differentiating between them before infection caused disfigurement of one. At the age of twelve, a nasal operation followed by infection destroyed a portion of the septum, and this loss of cartilage produced a deep notch in the bridge, thereby causing a shortening and widening of the nose, and an elevated and narrowed upper lip. She was now quite unlike her twin sister, her once beautiful profile being destroyed, and causing her to develop an inferiority complex. The sisters, who dress identically and are inseparable, are motion picture actresses and naturally such a deformity became a travesty. Although artists covered her sunken nasal bridge with wax and make-up for screen work, the defect was still recorded by the camera. (See Fig. 3.)

A reconstructive rhinoplasty was a very delicate procedure, for she asked to be made to look exactly like her twin, as she did before the loss of the nasal septum. The sister's nose was used for a model and guide. Face masks, photographs and models of both girls were made for study and accurate measurements were taken. Two cast metal appliances were constructed. A splint was cast in silver from an impression taken from the carefully sculptured nose, of the desired anatomical shape for the purpose of moulding the tissues during postoperative regeneration of the tissues. A cast metal model was used for exact duplication in cartilage to fill the defect. Two sections of cartilage were removed from the region of the eighth and ninth ribs. One piece was carefully carved similar to the metal model, and the other piece was implanted in the adipose tissue under the skin of the abdomen for future use, if necessary. The results of this reconstructive rhinoplasty and the remodeling of the upper lip were highly satisfactory. In this instance it has meant not only the eradication of a rapidly developing inferiority complex, but the continuation of her success on the screen. (See Fig. 4.)

* * *

Case 3.—Male, aged twenty-two years. Congenital unilateral cleft palate and cleft lip. There is a history of nine operations between the ages of two weeks and fourteen years. The result of these surgical procedures shows an unsightly profile, a very narrow and contracted upper lip, everted lower lip hypertrophied to

Fig. 3

Fig. 4

Fig. 3 (Case 2).—Identical twins. Note the nose of the lower twin; how it is shortened, depressed and notched. Also drawn facial expression.

Fig. 4 (Case 2). Identical twins. Note the profile and improvement of facial expression. Nose reconstruction by transplantation of cartilage from rib and followed by anatomic moulding.

three times its normal size, a large cleft in hard palate, a soft palate wide open and a very short, flat, broad nose. At the previous operations, the surgeon failed to close the clefts in both hard and soft palates, and to reconstruct and remodel the nose. He also excised the premaxillary bones. (See Figs. 5 and 6.)

This patient has suffered all of his life, both functionally and socially, from his bad appearance and his speech impediment. He developed a feeling of being unwelcome in school or in the business and social worlds. The rebuilding of his face and mouth has required many operations, consisting of:

1. Lengthening of upper lip.
2. Reduction of lower lip.
3. Narrowing of nose and reshaping of nares.
4. Closure of cleft in hard palate.
5. Closure of cleft in soft palate by "push back" operation.
6. Construction of special dental appliance.
7. Lengthening of nose and elevation of nasal tip by transplantation of cartilage.
8. Lengthening of columella by utilizing the tubed graft secured from the chest.
9. Widening of upper lip by utilizing the tubed graft secured from the chest.
10. Reconstruction of philtrum and cupid's bow.

This long series of plastic work would have been unnecessary, if the patient had had skillful reconstructive surgery in infancy. He would have been spared, also, an unhappy life of impaired function and mental anguish. (See Figs. 7 and 8.)

* * *

Case 4.—Female, aged twenty-five years. The nose of this young woman has been injured at birth, due to misuse of forceps. Being in public life as a school teacher, she had developed an inferiority complex. She stated that from early childhood she had been acutely conscious of her deformity, and had suffered mentally because of her appearance. Not only had the acquired nasal disfigurement impaired her personal appearance, but the constricted nares prevented normal breathing. The accompanying photograph, illustrated in Fig. 9, shows the nose to be elongated, with a broad, flat, depressed tip, an excessive "hump" and abnormally shaped nostrils.

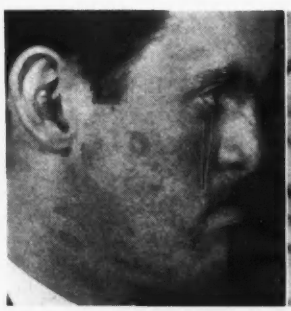

Fig. 5

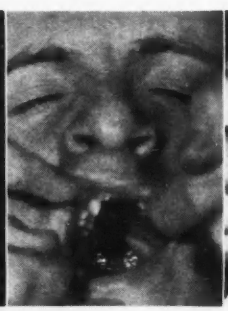

Fig. 6

Fig. 7

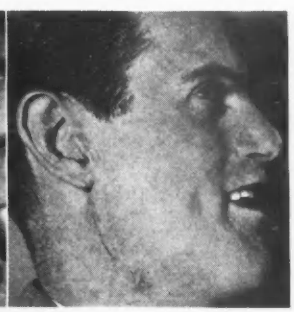

Fig. 8

Fig. 5 (Case 3).—Note unsightly profile due to congenital cleft palate, cleft lip and bad surgery. Note short, flat, broad nose, short columella, broad nostrils, retracted upper lip, protruded and hypertrophied lower lip.

Fig. 6 (Case 3).—Note cleft palate, wide nostrils and flattened nose. The premaxillary bones had been excised when a baby.

Fig. 7 (Case 3).—Note the closure of the cleft of soft and hard palates by the Dorrance "push back" operations.

Fig. 8 (Case 3).—Surgery completed. Showing results accomplished from numerous reconstructive operations. Compare profile with Fig. 5.

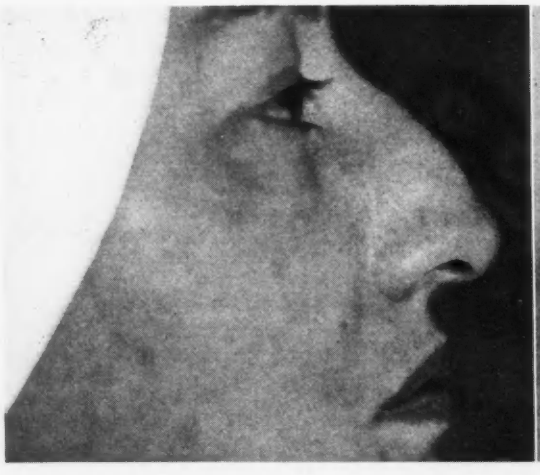

Fig. 9

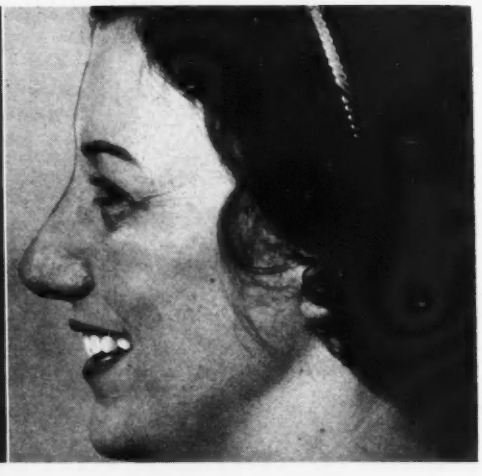

Fig. 10

Fig. 9 (Case 4).—An acquired nasal deformity by misuse of forceps at birth. Note the excessive size, prominent "hump" and length.

Fig. 10 (Case 4).—Result obtained from corrective rhinoplasty. Operation "in toto" was done.

The surgery consisted of reducing the protruding nasal bones, shortening and lowering the septum, narrowing and pointing the tip, elevating the columella, reshaping the nostrils and reducing the nasal processes of the superior maxillary bones. The photograph, illustrated in Fig. 10, was taken three months following surgery, and attention is called not only to the improvement in the nasal form but to the facial contour, with a widened upper lip and pleasing expression. This young lady has developed an entirely different mental attitude, is not depressed, and her inferiority complex has vanished due to the restoration of normal breathing and improvement in her personal appearance.

* * *

Case 5.—Female. This patient gave a history of having a lower right third molar removed with prompt healing of the socket, without pain. Six months later a fistula appeared in the lower right face. She consulted several doctors and dentists, and numerous x-ray films have been taken. When examined, her only complaint was of a copiously discharging fistula on her right face which required frequent change of dressings.

Examination showed that this patient practiced efficient oral hygiene. No intra-oral lesions could be found. Bacteriological examination of smears, from both the external opening and the inside of the fistulous tract, revealed numerous pus cells, gram-positive and gram-negative bacilli, fusiform bacilli and spirilla. These findings were indicative of Vincent's infection. A small blunt probe was inserted into the fistulous tract, which was found to extend to the third molar socket.

Treatment consisted of opening of the third molar area by incising the apparently healthy mucoperiosteum covering the area. The fistulous tract was treated by irrigations. Two intravenous neosalvarsan injections were given. After three days no discharge

Fig. 11

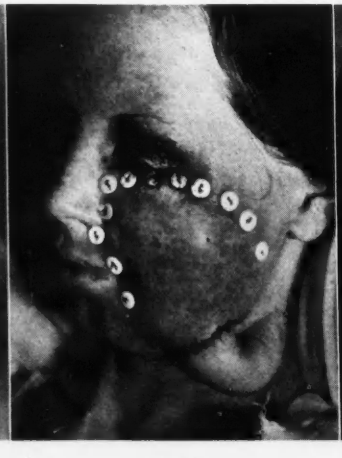

Fig. 12

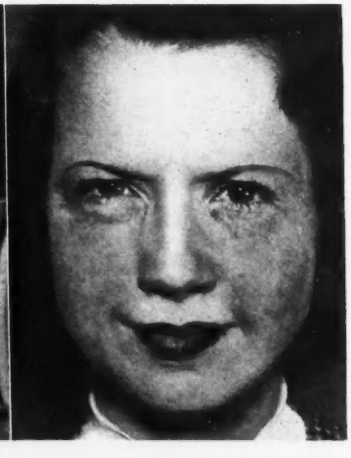

Fig. 13

Fig. 11 (Case 6).—Illustrating the tubed pedicle graft which was used to reconstruct the left face.

Fig. 12 (Case 6).—Illustrating the tubed graft in position three days after operation. The buttons were used to prevent injury to skin from sutures.

Fig. 13 (Case 6).—Surgery completed. The tubed graft was spread out and inserted through a one-inch incision beneath the left jaw, which restored normal facial contour of the left cheek, eyelid, nasal ala and upper lip.

was apparent, and in ten days the tissues were apparently healed. This long continued infection had caused an adherence of the skin to the mandible at the fistulous opening, destroying the normal surface contour and resulting in an unsightly scar.

The adherent scar was separated from the mandible, the surrounding subcutaneous tissues were approximated, and the normal surface contour was restored.

* * *

Case 6.—Female, aged twenty-two years. At the age of ten this patient was struck with a baseball on the left side of the face. The impact fractured the anterior wall of the antrum, the malar bone and the infra-orbital margin of the superior maxillary bone. The x-ray revealed almost complete obliteration of the superior maxillary sinus. Examination revealed that the left cheek and the tissues covering the infra-orbital margin were depressed. There was an ectropion of the lower left eyelid, and the left ala was widened and distorted, with the left angle of the mouth drooping and pulled to the left side. The natural contour was destroyed, there being a concave surface instead of the normal convex outline. Measurements revealed that the concavity of the left side of the face was three-quarters of an inch beneath the normal contour line, as compared with that of the right. The thickness of the cheek at the deepest portion of the concavity was an eighth of an inch, and gave the impression to the palpating fingers that only skin and mucous membrane were present. (See Fig. 11.)

A tubed flap containing considerable adipose tissue was prepared from the skin on the left side of the abdomen and was transferred in four steps to the face. An incision, one and one-quarter inches long, was made parallel to the lower border of the left mandible. The skin was carefully loosened from the underlying tissues at the angle of the mouth, beneath the ala, and into the lower eyelid and extending one-half inch anterior to the left ear. The lower end of the tube was opened and the tissue modeled to a form constructed prior to operation. Equidistant sutures were placed in the margin of the flap. The graft was placed in position and the sutures were tied over buttons. Three weeks later the tube was severed, the lower portion of the graft was shaped to the proper contour and the skin incision closed. (See Fig. 12.)

Illustration 13 shows the restoration of normal facial contour and left ala. The lower eyelid and lip are normal and there is restoration of expression.

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DISCUSSION

William S. Kiskadden, M. D. (1930 Wilshire Boulevard, Los Angeles). — The author has covered the general field of reconstruction surgery briefly, but thoroughly; and with one or two minor exceptions, I am in accord with his ideas.

It has not been my experience that either total or partial absence of the eyelids is easy satisfactorily to correct. Moreover, my experience with the removal of tattoo marks, skin discolorations, or chemical staining has left a rather deep impression of how difficult, and sometimes disappointing, is the treatment of these conditions.

I am glad that Doctor Smith mentioned the deformity and malformation that may result in noses following slight or forgotten injuries in childhood. I feel that these should be treated conservatively when discovered, and if the distortion is not too severe or disfiguring it is wiser to postpone surgery till the age of sixteen, when growth of the nose has usually ceased. Treatment before this time may give a good immediate postoperative result, but subsequent growth often causes even worse distortion than existed preoperatively.

The treatment of keloid following burns is one of the many ever recurring problems that the plastic surgeon faces. X-ray, of course, in small, divided weekly doses, is of distinct value. However, the implantation of skin in the form of a graft, either split skin, whole thickness or pedicle in type, will often result in amazing smoothing, thinning, and softening of the surrounding thick keloid. The rationale of early grafting of all burns or denuded surfaces as a preventive against keloid formation and subsequent contraction, is obvious.

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Francis L. Anton, M. D. (702 Wilshire Medical Building, Los Angeles). — The plastic surgeon must combine science with art to an eminent degree. He must add to these qualifications no small amount of moral courage, because his success or failure is a constant walking advertisement of his work. Good surgical judgment and a great amount of patience are also required. Many of these reconstructive undertakings require months and sometimes years for their ultimate accomplishment, and oftentimes can only be done a step or two at a time.

Great, indeed, however, is the satisfaction of being able to convert a repulsive monstrosity—for instance, a cleft lip or palate case—into an acceptable member of the human society; and it is well worth the time and patience devoted to it. Disabling or disfiguring scars, as well as other and greater deformities, whether congenital or acquired, frequently produce an inferiority complex in the possessor of such defects which makes him very unhappy and reduces his usefulness.

Since well-trained scientific men have become interested in this work and have taken it out of the hands of charlatan beauty specialists, great progress and healthy improvement in the work has developed.

The unsatisfactory and often dangerous injection of paraffin has been replaced by tissue transplantation to fill out defects and sunken areas. Bone and cartilage transplantations are placed where a more solid support is needed. The transplantation of tendons and nerves often produces most wonderful effects in infantile paralysis, and in cases of industrial or automobile accidents.

*

George Warren Pierce, M. D. (490 Post Street, San Francisco).—It is true that there is a lack of knowledge concerning the scope and capacity of reconstruction surgery, not only among the laity, but also to a considerable extent throughout the medical profession. However, I wish that Doctor Smith had given us for this meeting less of a catalogue of the possibilities of this specialty and more of discussion of the refined technique that is required in dealing with its varied problems.

I will frankly criticize one of Doctor Smith's statements—that "acquired and congenital deformities of the eyelids, with total or partial absence, are easily corrected." To me, reconstruction of an eyelid for total absence is most exacting and difficult, and if Doctor Smith will tell me how it can be easily corrected I will be most grateful.

Of special interest was the case of correction of the deformities following the badly operated cleft lip and palate. In the light of our present knowledge deformities such as these are inexcusable. The surgeon who undertakes to "do" a cleft lip and palate should be certain that he can offer to the patient a more than fair chance to receive a lip which will offer an almost normal appearance, a reconstituted musculature and function, and a nose whose columella is in midline with alae and nostrils approximately similar. He should be confident that he can give the patient a long palate with mobile velum which will permit speech free from the characteristic cleft palate enunciation.

The majority of surgeons who do a large number of cleft palate operations agree that the use of wires and plates, after the technique of Brophy, is detrimental to the best results, and that their use arrests development of the superior maxillae and is apt to destroy the tooth buds. Far better average results are obtained by reconstructing the lip and nose, and allowing the constant elastic action of the reconstituted orbicularis oris to gradually mold the protruding alveolar process into normal position, which it surprisingly does. The secret of primary healing of the palate

and velum is absence of tension on the suture lines. This can only be obtained by free dissection around the posterior end of the alveolar process. If this freeing of the tissues is efficient, no stay sutures or wires are necessary.

*

DOCTOR SMITH (Closing).—I wish to thank Doctor Pierce for his taking exception to my statement, *i. e.*, "Acquired and congenital deformities of the eyelids, with total or partial absence, are easily corrected." Possibly the word "easily" should have been omitted, because all plastic operations of any magnitude upon the face demand painstaking and exacting surgical technique, and also the application of mechanical principles. The results obtained, both functional and cosmetic, from reconstructive operations on eyelids upon patients coming under my observation have been most encouraging and gratifying. In some of these cases the eyelid was not only reconstructed, but eyelashes were restored. Other operations which are difficult are the restoring of an ear, nasal ala, and lip. Restoration of function and cosmetic appearance are paramount. As time passes, and as I become more and more familiar with the almost unlimited intricacies of reconstructive plastic and oral surgery, I am convinced that one not thoroughly trained in this highly specialized branch of general surgery should not attempt it. It is seldom that two plastic or oral cases are alike, therefore each case demands individual study and preoperative planning in order to determine the proper method of reconstruction. The case should be studied from every standpoint. Efficient results are based upon sound surgical and mechanical judgment, and the determining of just what should be done. Surgery of this type cannot be done in a hurry. A single operation of a complicated case may require several hours, due to the great detail and difficulties encountered. In many cases numerous operations are necessary to accomplish a good functional and cosmetic result.

SURGICAL RELAXATION*

By JOHN ROBERT BURROWS, M. D.
San Francisco

DISCUSSION *by Caroline B. Palmer, M.D., San Francisco; Mary E. Botsford, M.D., San Francisco; W. V. Chalmers-Francis, M.D., Los Angeles.*

SURGICAL relaxation is a problem that confronts the anesthetist each time an anesthetic is administered. Considering the various types and conditions of patients that are presented, can full relaxation always be given, maintaining, at the same time, the safety of the patient and acceding to the demands of the surgeon? Let us review, briefly, the more common methods and agents of anesthesia, with consideration of their safety and efficiency.

SPINAL ANESTHESIA

Spinal anesthesia, of all anesthetic agents, in that part of the body affected, gives the most complete relaxation. In recent years its safety has been increased by improved technique, the use of less toxic agents, and also of ephedrin and CO_2 and O. Its effect, however, is limited in duration. This can be controlled to a certain extent by the amount of the agent administered and, more recently, by the combination with novocain (the most commonly used agent) of such drugs as pantocain and nupercain, which have a longer duration of action than novocain. Pantocain and nupercain are more toxic than novocain, though that, to a degree, is made up for by the smallness of the dose required. Nevertheless, while the safety of spinal anesthesia has been decidedly increased, there still seems much to be desired. Alarming drops of blood pressure continue to occur; likewise, marked circulatory and respiratory depressions. The debate as to its safety still continues, and the great majority decline to use spinal anesthesia for operations above the diaphragm. Mortality has been placed anywhere from one in three hundred to the claim of no mortality whatever. It certainly has its place in anesthesia, especially when used in selected cases, though the popularity of a few years back would appear to be decreasing. There seems to be very little difference in postoperative pulmonary complications between this anesthetic agent and others. The height of the anesthesia apparently is not as controllable as one would be led to believe, similar doses and similar amounts of fluid not infrequently giving quite different results.

Other forms of regional anesthesia are decidedly safer than spinal, though occasionally a patient may have an idiosyncrasy against the agent used; and it may show a lack of efficiency in itself and so require the addition of some inhalation anesthetic.

CHLOROFORM AND ETHER

Chloroform gives an excellent degree of relaxation; but its high toxicity and its danger to the patient, both immediate and remote, have rendered its use unjustified.

Ether ordinarily gives a good relaxation; and though its toxicity is fairly high, it has a wide margin of safety. It is true that it tends to be somewhat irritable to pulmonary tissue, and is contraindicated in pulmonary affections. Likewise, it is not suitable in cases with kidney complications. Taking it altogether, the writer believes that ether, properly given, has a high degree of safety, and it would seem that postoperative complications, following ether, are due to the location of the operation rather than to the anesthetic agent.

NITROUS OXID AND ETHYLENE

Nitrous oxid with oxygen is a very safe anesthetic when properly given. It is rapidly absorbed and rapidly eliminated. Its toxicity is apparently nil, and muscle tone is not lost. In those cases requiring a full relaxation, it would be necessary to use, in addition to nitrous oxid and oxygen, either a local infiltration or the addition of ether, and proper premedication is absolutely necessary in any case for a smooth anesthesia with this agent. McKesson, by what he terms a secondary saturation, seems to be able in at least the large majority of his cases to obtain relaxation suitable for any case with nitrous oxid and oxygen alone.

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* From Stanford University Hospital.

Read before the Anesthesiology Section of the California Medical Association at the sixty-third annual session, Riverside, April 30 to May 3, 1934.

While, in his hands, this procedure seems successful, both as to relaxation and safety, it has not been found so in the hands of others, and the writer cannot help but feel that it is not justifiable.

The same that has been said of nitrous oxid may be said of *ethylene*, except that ethylene gives somewhat more relaxation, and a higher percentage of oxygen can be used.

INTRATRACHEAL ANESTHESIA

The *intratracheal* administration of anesthetics gives a very satisfactory relaxation, though it requires a deep etherization to permit the passage of the tube into the trachea, or, as used by some, a topical application of a strong solution of cocain; also, there is some danger of injury to the vocal chords or the pulmonary tissue.

ETHYL CHLORID

Ethyl chlorid is usually used for very short operations and will, in such cases, give a fair relaxation, though sometimes masseteric spasm will interfere. Its safety probably lies somewhere between ether and chloroform.

AVERTIN

Avertin, used as a basal anesthetic, and in the dose calculated by bodyweight, seems to be a fairly safe procedure. It should never be used as an absolute anesthetic. With the addition of nitrous oxid and oxygen, it gives a fairly good relaxation, and permits at the same time a larger percentage of oxygen with nitrous oxid, or a lesser amount of ether. Used with a local anesthetic, its action is not always so satisfactory. There seems to be quite a variation in analgesia, as well as in relaxation, in patients apparently requiring similar doses. As it may be given in the room, and the patient be asleep before being brought to the operating room, it is particularly useful in apprehensive and very nervous patients.

PREANESTHESIA MEDICATION

As premedication before anesthesia, it has been found that the *barbitals*, with their hypnotic, sedative and antispasmodic action, are extremely useful, combined with morphin or pantopon. *Sodium amytal* not infrequently will give a certain degree of excitement, which seems to interfere with a smooth induction of anesthesia. Any one of the barbitals, given in a large dose, is very apt to interfere with the successful maintenance of anesthesia by reason of a depression of respiration. The intravenous use of the barbitals we, at Stanford University Hospital, agreeing with the Council of the American Medical Association, feel is not justified, believing that equally good results can be obtained in the anesthetic field in the use of such drugs by mouth.

With *scopolamin* we have had too many cases of depressed respiration to make us feel justified in its routine use.

PROCEDURES PRIOR TO OPERATION

Now, let us speak of such things, prior to operation, as will help the anesthetist in the proper administration of the anesthetic, and which will aid in obtaining the proper degree of relaxation required. First, proper preparation; secondly, a restful night, usually to be obtained by a small dose of some sedative; and, lastly, a proper dose of some barbital administered previous to operation, and followed by morphin or pantopon. After administration of the barbital, the patient should be kept as quiet as possible, and from then on with as little excitement as is possible. The effect of premedication has often been destroyed by the visits and conversations of well-meaning friends. The removal of the patient to the operating suite should also be done as quietly as possible, and the patient placed in a suitable position on the table so that there is no strain on any of the muscles. This matter of unstrained position is exceedingly important. After then having been moved quietly to the operating room, and a few reassuring words spoken to the patient, the anesthesia should be started in as unhurried a manner as possible. Many anesthesias have been spoiled by someone saying "to hurry." The usual result is a rough induction, ending in overdosing the patient. The administration of any inhalation anesthetic requires at least ten minutes (some say fifteen) to obtain the state of surgical anesthesia. Another thing; an unobstructed airway is absolutely essential, and most important in the maintenance of a smooth anesthesia.

FACTORS ANTAGONISTIC TO SMOOTH ANESTHESIA

Those things that will work against the anesthetist in obtaining a smooth anesthesia will be the nature of the patient, his habits and mode of life, improper preparation, the giving of too much or too little premedication, a hurriedly given anesthetic, or an incision made too soon, and, during the operation, a strained position (which is not always avoidable), but, perhaps most important of all, a partially obstructed airway.

THE RESPONSIBILITIES OF THE ANESTHETIST

After the anesthetic is begun, the anesthetist's entire attention should be concentrated upon the patient; but in order to give an intelligent anesthetic, the writer feels it to be necessary that the anesthetist have some knowledge of what the surgeon is doing, for in a great number of operations, as we all know, it is not necessary to keep the anesthesia on the same level. As, for instance, in a gastro-enterostomy, when the bowel and stomach are in a position to be sutured and the retraction has been lessened, anesthesia may be lightened considerably, deepening it again a little before the surgeon is ready to replace the organs in the peritoneal cavity. Should the respirations tend to become shallow, or jerky, or straining in character, the addition of carbon dioxid, either by rebreathing, or directly with oxygen, will tend, by causing the respiration to become deep and regular, and possibly by some antispasmodic action of the carbon dioxid, to smooth out a rough anesthesia into a quiet one, and so help to main-

tain surgical anesthesia more easily and quietly. The amount of relaxation obtained will depend upon the amount of anesthetic agent given and its potency.

ON THE DEGREE OF RELAXATION REQUIRED

The degree of relaxation required in the average case will depend a great deal upon the site of operation and the nature of the work to be done. Intra-abdominal work, especially about the gall-bladder and stomach, and deep pelvic operations, require the deepest anesthesia. Surgeon and anesthetist, both, have first in mind the safety of the patient; next, the most efficient way, on the part of the surgeon, in which the work can be performed, his objective being to correct some pathological condition. The anesthetist, on his part, wishes to administer such an anesthetic as will enable the surgeon to perform his work as easily and efficiently as possible. Of course, if this can be done in as agreeable a manner as possible to the patient, so much the better; but safety and efficiency must come first. The anesthetist's procedure will depend upon the operation to be performed, and upon the needs or demands of the surgeon. Every surgeon differs in his technique, and in the degree of relaxation he demands; from those who have accommodated their technique to the limitations of nitrous oxid and local infiltration, on through to those who will demand the very deepest of anesthesia, especially in any abdominal work.

The effect upon the patient will depend upon the potency of the anesthetic agent, which, generally speaking, will vary directly with its toxicity, the length of administration, and upon the rapidity with which it is eliminated. The anesthetic agent and method of administration must be chosen according to the condition of the patient, as well as the needs of the surgeon. The advisability of great muscular relaxation will likewise depend upon the condition of the patient and the limitations of the anesthetic selected.

SPECIAL CASES

It occasionally happens that a patient is found who, although proper preoperative preparation has been given, will not yield the desired relaxation, even though carried to the deepest depths of anesthesia that safety permits. The writer has, on more than one such occasion, been forced to refuse to carry the anesthesia deeper because the patient was then verging upon the fourth stage, while the surgeon was still not satisfied with the relaxation obtained. In some such resistant cases, where a large amount of ether had previously been given, the writer has been asked to add a little chloroform. This he did on two occasions, the dose not exceeding ten drops, slowly given, but with almost fatal results.

Complete surgical relaxation is *not* possible in all cases, without danger to the patient. For instance, when the writer first witnessed the operation for the relief of hypertrophic pyloric stenosis, it was done by gastro-enterostomy, which required a deep anesthesia and was a comparatively long procedure that required deep relaxation. The mortality following this procedure was high. When Weeks introduced in San Francisco the Fredet-Ramstedt operation, the procedure was short, and he required the lightest possible anesthesia, with the result that his mortality was very low.

IMPORTANT TO RECOGNIZE THE LIMITATIONS OF AN ANESTHETIC

The question of recognizing the limitations of an anesthetic agent cannot be too strongly stressed. It is just here that the coöperation of the surgeon is particularly important. Let us take, for example, after consultation, a patient has been declared suitable only for either nitrous oxid and oxygen or ethylene, combined with local infiltration. After the operation is under way the surgeon, for some reason or other, demands the addition of ether to gain further relaxation, with the result that the patient may be lost.

An associate of the writer was once called in consultation by a surgeon as to whether an anesthetic could be given to a certain patient whom, the internists had declared, would die without surgical interference and who, on the other hand, would not be able to take an anesthetic. The anesthetist expressed the opinion that with the use of nitrous oxid and oxygen there was a fighting chance, provided the surgeon would coöperate with her as to the limitations of the anesthetic agent, and agree to stop his manipulation if the patient became roused, and wait until the patient was again under control. Under these conditions the operation was performed and the patient left the hospital in good condition, dying some years later from a complaint entirely foreign to that for which he had been operated upon.

NEED FOR CLOSE COÖPERATION BETWEEN SURGEON AND ANESTHETIST

There is no intention in this paper to presume to dictate to the surgeon as to how his work should be done, nor to criticize his procedure, but only an earnest desire to show the necessity and benefit of closer coöperation between surgeon and anesthetist. Above all things, we do not want to work at cross-purposes with him. If something should go wrong with the anesthesia, or the patient does not reach the desired stage of surgical anesthesia as quickly as usual, it would certainly be much more beneficial to all concerned that all manipulation cease until the difficulty is straightened out, or the desired degree of relaxation is attained. Otherwise, one is not only more than apt to cause interference in the operating procedure but, also, to overdose the patient. The anesthetist, it is true, should try to anticipate the surgeon's needs; but he cannot always foresee the next move, and it would indeed be helpful if some unusual manipulation is contemplated, which will require deeper anesthesia, to be warned of it.

The wish of all of us is to administer an anesthetic that is safe to the patient and efficient

for the surgeon's needs, and, if possible, agreeable to the patient; but safety and efficiency must come first.

IN CONCLUSION

1. Complete surgical relaxation is not safe, necessary, or possible, in every case.

2. The anesthetic agent must be chosen according to the condition of the patient.

3. Recognizing the limitations of the anesthetic agent is most important.

4. Coöperation between surgeon and anesthetist is particularly essential.

2401 Sacramento Street.

DISCUSSION

CAROLINE B. PALMER, M. D. (2904 California Street, San Francisco).—I would like to stress one of the points brought out in this paper because of its great importance.

The failure to take into consideration the limitations of certain anesthetics leads to poor anesthesia and is often fraught with danger.

Most physicians and surgeons know that nitrous oxid and oxygen alone can give but slight relaxation, and yet anesthetists are frequently asked to administer this anesthetic for operations requiring marked relaxation. Worse still, the request is sometimes made that no premedication be given. This necessarily spells failure, and commonly leads to the use of ether in cases where ether is contraindicated.

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MARY E. BOTSFORD, M. D. (807 Francisco Street, San Francisco).—Doctor Burrows' timely paper might aptly be named "The Dangers of Surgical Relaxation," and the answer to the question he asks as to the possibility of obtaining full relaxation safely in every case is emphatically no. Some research done at Johns Hopkins Medical School a few years ago by Gatch and Mann showed the cause of many anesthetic deaths to be the determination of blood to the valveless splanchnic area, producing cerebral anemia when the anesthetic is pushed to the deepest stage in order to obtain muscular relaxation. Probably much of the mortality of spinal anesthesia is due to this relaxation of intestinal muscle tone.

The need for preoperative medication is clearly shown: the combination of hypnotics and sedatives, such as the barbiturates, avertin and similar drugs, selected for the individual case, is of the greatest value in reducing the amount of the anesthetic agent necessary to produce sufficient relaxation for the operative procedure.

The necessity for the anesthetist to be aware of the stages of the operation, so that the depth of the anesthesia may be increased or lessened accordingly, is well emphasized and is a strong argument for the medical anesthetist.

The status of the anesthetist as "physician of the surgical team" is demonstrated, as is his value to the surgeon in relieving him of the necessity of "supervising" the administration of the anesthetic, since the individual reaction of the patient can be recognized only by the anesthetist.

Crile has proved the advantages of light anesthesia and the possibility of the performance of every surgical procedure by gentle manipulation, rather than by the method which he terms "insulting the peritoneum." The extremes of age, even such limits as five hours and ninety-six years, offer no bar to safe anesthesia, provided deep surgical relaxation be not required.

The conclusion drawn is that the true criterion of an anesthesia is not depth, but safety.

W. V. CHALMERS-FRANCIS, M. D. (1136 West Sixth Street, Los Angeles).—Surgical relaxation is an unknown quantity. In practice, to one surgeon the light stage of anesthesia is perfect for his technique, to another surgeon no stage less than the deepest, most risky narcosis is satisfactory to his special abilities.

Spinal anesthesia gives complete relaxation, comparable to that in death, following the passing of *rigor mortis*; it is safer than ten years ago, but the anesthetist differs from the surgeon, who bases his success on percentages of his results, while the anesthetist figures on the 10,000 to 100,000 valuation of his cases. Spinal anesthesia deaths are in the 1 to 100-1000 valuation; nitrous oxid and ether in the higher records, up to 1 in 70,000. We feel the relaxation of spinals is to be valued in "the safety of the patient," and we compare it with the safety of "balanced anesthesia" (the use of local with the general administration of gas inhalations), with gas-ether sequence, or ether alone, and find spinal wanting in comparison with their safety margin, even today. We talk "selected cases" and hesitate to support it as comparable to the use of other dangerous drugs we prescribe the dosages of; diagnose their reactions with the individual patients and treat these varying conditions every moment as they indicate to our judgment and skill.

Chloroform is the best inhalation anesthetic today, in so far as relaxation is obtainable, but it is disapproved of because of its marked toxicity and late effects. In competent hands it can and is used with a high degree of success, but the use is to be depreciated when compared with other inhalation anesthesia on the basis of "safety to the patient." However, in use as an adjunct to ether in small dosages it shows a higher margin of safety than spinal (Dr. A. H. Miller Fiske Fund Essay, R. I. Med. Jour., September 31) and aids in relaxation with marked value.

Ether in the hands of most of us is the safest relaxation producer we have after one hundred years of usage. In expert hands it is practically free of serious complications, and postoperative vomiting and lung changes are avoidable to a large extent. Incidentally, if half the effort devoted to studying spinals and gas anesthesia were expended to train men to the proper application of ether, very few would use other inhalations.

In my opinion no good relaxation is obtained with "gas" anesthesia, be it nitrous or ethylene gas alone. To obtain relaxation one must use "combined anesthesia," that is, to use barbiturates, opiates, scopolamin, etc., followed up with gas inhalation anesthesia to produce relaxation. Here is the best work done, from the patient's point of view; an important matter. Add to this the technique of apnea production, the filter method, with rebreathing, many will be won to their daily use and teamwork.

The potency of drugs varies with the metabolic rate: the metabolic rate is varied by many conditions, *e. g.*, age, fever, thyroid activity, fear, etc. The potency of N_2O varies with that of ether and chloroform. To relax a patient we must work within the area of potency of the drug, which varies as fear, etc., raise the metabolic rate and lower the potency; this must be considered and diagnosed, and controlled by premedication with barbiturates, morphin, etc. All these considerations demand consultation and understanding by both the surgeon and anesthetist; for as much more as the surgeon knows his surgery, so much less does he know his anesthesia, the two fields, coöperating in the operating room, separate widely in their fields of study outside their close contact at the table, and few can or do devote their reading and study to both investigations.

Doctor Burrows has covered the ground so well that the value stressed is forever before the profession for impressive guidance.

COMMON DERMATOSES—SOME UNUSUAL MANIFESTATIONS*

By Nelson Paul Anderson, M. D.
AND
Samuel Ayres, Jr., M. D.
Los Angeles

Discussion *by John M. Graves, M. D., San Francisco; Ernest D. Chipman, M. D., San Francisco; John L. Fanning, M. D., Sacramento.*

THE purpose of this paper is to record and present some of the less common conditions which occasionally occur in conjunction with the more common skin diseases.

VERRUCA VULGARIS A FREQUENTLY SEEN DERMATOLOGICAL CONDITION

Verruca vulgaris is one of the most common dermatological conditions, particularly in children of school age. Involvement of the mucous membranes by the virus causing common warts is distinctly uncommon. We have seen one such case recently where the entire mucous membranes of the lips and even the gums were involved. There were a tremendous number of pea-sized and smaller papillomatous lesions present (Fig. 1). The infection in these cases is probably transferred from hands to mouth, as they are usually seen in children who have warts on the hands or about the finger nails, and who are in the habit of biting their nails. In this connection it is interesting to speculate concerning the origin of laryngeal papillomas. We know from experimental work that the virus producing papillomas of the larynx is very similar to if not identical with that causing the common wart. As far as we know, no common wart has ever taken on malignant characteristics, and yet papillomas of the larynx are definitely a precancerous condition.

PITYRIASIS ROSEA

We are all acquainted with the cutaneous manifestations of pityriasis rosea. It is rather uncommon, however, for this condition to involve the face to any marked degree. Such an instance of facial involvement is well shown in Figure 2. Very rarely, the mother spot may appear on the shaft of the penis. Gigantic herald spots have been reported. Hemorrhagic forms of pityriasis rosea occasionally occur.

PHYTID ERUPTIONS OF THE HAND

The so-called "phytid" eruptions of the hands as a complication or accompaniment of fungus infections of the feet, are familiar to us all. Lichenoid trichophytid eruptions of the trunk occur in connection with ringworm of the scalp, particularly infections of a kerionic nature, or after epilation of the scalp hair by x-ray.

FUNGUS INFECTIONS OF THE FEET

Certain cases of fungus infection of the feet are accompanied by pityriasiform eruptions of the trunk. At times, these eruptions are indistinguishable from pityriasis rosea, and the differentiation can only be made after a period of observation. We might mention also a case where the external ear was the seat of an actual infection with the epidermophyton fungus, the organism being isolated from the scales.

RINGWORM OF THE SCALP

Ringworm of the scalp is, for all practical purposes, limited to children under the age of puberty. In the past few years, however, we have seen three cases of ringworm of the scalp in adults. In each of these cases the diagnosis was confirmed microscopically by the finding of spores in the infected hairs. In one of the cases the nails of the fingers were also involved, and the infection on the scalp had given rise to an atrophic scarring alopecia. No determination of the pathogenic fungus was made, although cultures were sent to two competent mycologists. The organism was definitely not that of favus.

TINEA VERSICOLOR

Tinea versicolor is a relatively common skin condition which we ordinarily pass by without comment. However, when the lesions are found on the face, as in a case recently seen, they are apt to be mistaken for chloasma, and it is uncommon to find this condition on the forearm and wrist, as in a recent case.

NEUROTIC EXCORIATIONS

Neurotic excoriations are generally seen on areas of the body easily reached by the hands, more particularly the face. We have encountered one case in which, in addition to lesions on the face and nose, there were large punched-out ulcerations of the gums and buccal mucosa. This occurred in an edentulous person.

PSORIASIS

In psoriasis the palms and soles are rarely affected. Most cases so diagnosed are proved eventually to be due to syphilis, occupational irritants, or eczema. It is possible for psoriasis to involve the palms and soles, as shown in Figures 3 and 4. The lesions are dry, erythematous, scaly patches, and occasionally have a verrucous aspect. Psoriatic patches on the mucous membranes do occur. In one case which we have seen, the patch simulated leukoplakia, but the intensity of the condition fluctuated with the severity of the psoriasis.

It would probably be best to avoid entirely such a controversial subject as pustular psoriasis. We had a case two years ago of a severe pustular eruption which occurred in a woman who had had a definite psoriasis for about fifteen years. The pustular aspect of the condition began during pregnancy and cleared following delivery. Whether this should be regarded as an impetigo herpetiformis, or a pustular psoriasis, is perhaps an open question.

LICHEN PLANUS

Lichen planus rarely involves the palms, and yet in a case recently seen there were numerous

* Read before the Dermatology and Syphilology Section of the California Medical Association at the sixty-third annual session, Riverside, April 30 to May 3, 1934.

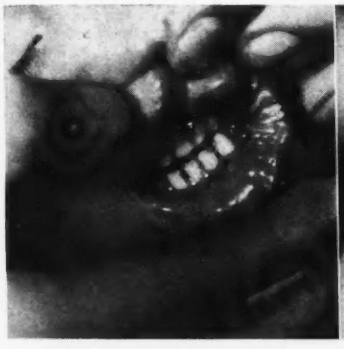

Fig. 1.—Verruca vulgaris involving mucous membranes of the mouth.

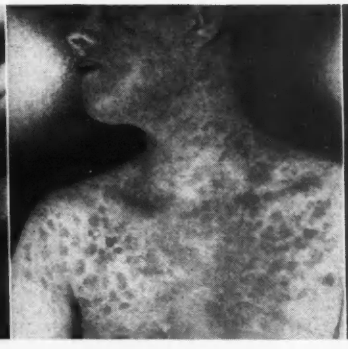

Fig. 2.—Pityriasis rosea with extensive involvement of face.

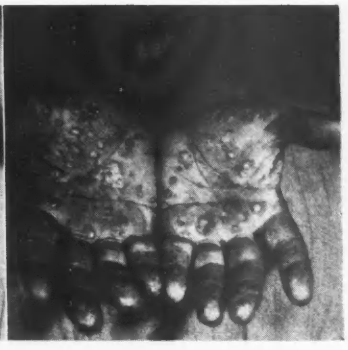

Fig. 3.—Psoriasis involving palms—an unusual location. (Same patient as Fig. 4.)

small papules present on the palms. Nail changes are certainly not typical of lichen planus, but we recently saw a case where there was scaling of the cuticle with a purplish discoloration of the nail. Both of the cases were accompanied by a marked generalized and acute eruption.

LUPUS ERYTHEMATOSUS

The common types of lupus erythematosus are too well known to require comment. There is, however, a telangiectatic type which is rarely diagnosed. Such an instance was presented in a recent case.

PEMPHIGUS

Pemphigus does occasionally occur in an isolated area, particularly on mucous membranes before becoming generalized. But a distinctly rare condition is presented by cases of pemphigus of the conjunctiva. This is also known as essential shrinkage of the conjunctiva.

SYPHILIS

Syphilis is, of course, the great imitator, and it is not in the province of this paper to more than merely mention some of its eccentricities. The occurrence of psoriasiform syphilis or zosteriform syphilis and its occasional tendency to mimic lupus erythematosus (Fig. 5) show clearly its ability to imitate many common skin conditions.

HERPES ZOSTER

The ordinary case of herpes zoster is familiar to all, but rarely this condition involves the mucous membranes of the mouth; and in one case, seen two years ago, there were lesions on the hard palate and an associated seventh nerve palsy.

Angiomas are not rare in children, and their location about the genitals is quite common. Yet we believe that involvement of the glans and shaft of the penis by such a nevoid process is rather unique.

CONTACT DERMATITIS

One could write a book on the unusual manifestations of contact dermatitis. The so-called "toilet seat" dermatitis and "match box" dermatitis, are not uncommonly seen. The face and hands, however, are the areas usually involved. It is interesting to cite a case in which, after a prolonged search, it was definitely shown that the eruption on the face was due to resin, with which the patient came in contact by two separate ways: first, through the use of resin on her violin bow,

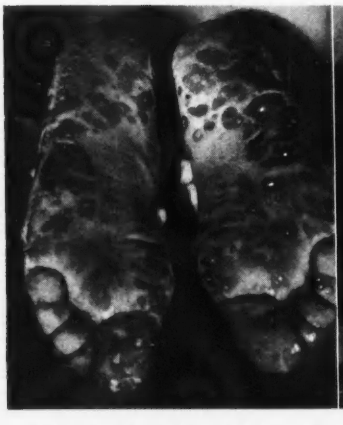

Fig. 4.—Psoriasis involving the soles—an unusual location. (Same patient as Fig. 3.)

Fig. 5.—Syphilis resembling lupus erythematosus.

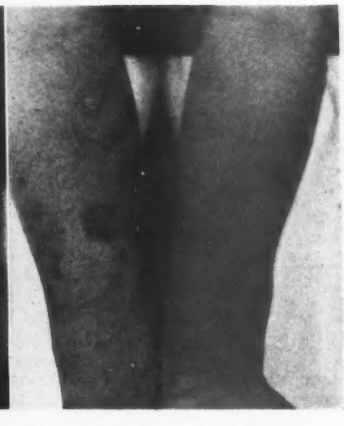

Fig. 6.—Nickel dermatitis from white gold wrist watch and positive patch test to a nickel chain on the right forearm.

and secondly through the use of resin on the dance floor, the patient being both a toe dancer and a violinist. A case of nickel dermatitis due to a wrist watch is shown in Fig. 6, with a positive patch test to a nickel coin showing on the right forearm.

ACNE

Acne, at the age of puberty, might be termed a physiologic process due to its frequency; yet infantile acne, although rare, does occur. Acne in middle age is also uncommon, excepting, of course, acne rosacea; yet we recently met with a case of acne which appeared following an exfoliating dermatitis due to arsenic. This patient had not previously been subject to acne.

SCABIES

Scabies is certainly one of our most common dermatological conditions which, however, at times may manifest itself in uncommon ways. All dermatologists are acquainted with those cases which present only an occasional burrow or papulo-vesicle, and whose chief manifestation is one that is generally and mistakenly called urticaria or hives. The persistent nodules which occur as infrequent sequelae to scabies are often overlooked or mistakenly diagnosed. These persistent nodules of scabies are probably what is termed, by the French, post scabetic keloids, which they resemble both in appearance and resistance to treatment. We have one case of arsenical dermatitis, which occurred in a luetic patient who developed scabies while receiving neoarsphenamin. The arsenical dermatitis apparently started following the use of sulphur ointment.

IN CONCLUSION

We have attempted to enumerate and briefly discuss some of the rarer types of eruptions which occur either independently of, or in conjunction with, some of the more common skin diseases.

2007 Wilshire Boulevard.

DISCUSSION

JOHN M. GRAVES, M. D. (909 Hyde Street, San Francisco). — There are two conditions mentioned by Doctor Anderson that I believe may be emphasized.

The treatment of tinea capitis was very unsatisfactory until the advent of the x-ray. The application of this method, of course, cures the vast majority of cases. Thallium acetate has been used for depilation, but it is too toxic for general use. As depilation is not always complete, this method too often fails to cure.

In recent years, local treatment has been used on the Pacific Coast with very satisfactory results. Doctor Kingery of Portland was the first, I believe, to revive this simple method. He recommends a combination of oil of cinnamon and thymol. Most patients are well within a period of from three or four months. This has been tried in other parts of the country with unsatisfactory results; but there is no apparent reason for this discrepancy.

One must distinguish carefully between uncured scabies and postscabetic nodules. The latter are possibly due to trauma induced by scratching. Fortunately, this is not a common aftermath of scabies. Measures to control the pruritus would seem to be indicated. If this be successful, the results are usually satisfactory.

ERNEST D. CHIPMAN, M. D. (2000 Van Ness Avenue, San Francisco). — The paper under discussion is of value for what it suggests, as well as for what it states.

The concomitance of lesions of different types, some of which may be merely coincidental, and some simply consecutive, gives to the analysis of eruptive elements a constant source of interest.

The fact that an individual has any certain dermatosis does not, of course, signify that immunity to other skin affections is thereby bestowed; if anything, the reverse is the more probable. And while the coincidence of non-related lesions often is noted, there frequently appear lesions which are definitely sequential; for example, the impetiginization of a simple dermatitis, the lichenification of any pruritic affection, etc.

A strikingly large number of dermatoses met with in practice are not textbook types. There are abortive, complex, and atypical forms. For this reason the examination of the entire surface is demanded. The obligation to avoid, as far as possible, all inferential diagnosis is also imposed upon us.

It is impossible to comment upon all the diseases mentioned in this paper; two will suffice.

Recently I have seen a giant herald patch which preceded a typical eruption of pityriasis rosea by approximately two months. Had I seen this lesion before the development of the general eruption, the diagnosis would have been most difficult. Since that experience, I have seen multiple (four) giant herald patches, accompanied by only faint generalized lesions. In each of these cases recovery was readily effected by the use of ultraviolet rays.

Concerning acne I believe we should differentiate sharply between the juvenile and the adult types. In the former, diet is of slight importance; in the latter, it may be paramount.

In some young adults, of course, the lesions represent the residue of a juvenile affection; but in the middle-aged subjects we must consider drugs, the general state of health and even the allergic response to certain foods, as well as diet in general.

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JOHN L. FANNING, M. D. (Medico-Dental Building, Sacramento).—Doctors Anderson and Ayres are timely in describing some of the pitfalls of the common dermatoses. Variants from the ordinary and usual are often deceiving, at the same time interesting and instructive, and force us to continuous alertness. We recently have seen eight cases of papular pityriasis rosea at the Sacramento County Hospital Clinic, all with a severe pruritus; and the next case of an apparently typical macular type later proved to be a "phytid" eruption, a complication of an acute fungus infection on the feet.

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DOCTOR AYRES (Closing).—We wish to thank the discussants for their remarks. In this paper we have attempted to present some of the curiosities which the dermatologist occasionally encounters among the common skin disorders.

Although our paper did not concern itself primarily with therapy, I would say, in answer to Doctor Graves's comments on the treatment of scalp ringworm, that we have not found it necessary to resort to x-ray or thallium epilation. We do insist, however, on treatment of the entire scalp after a preliminary shaving, and we remove by forceps the infected hairs, instructing the parents in the technique. Our local treatment has consisted in alternating between Whitfield's ointment, tincture of iodin, Castellani's carbol fuchsin dye and 10 per cent ammoniated mercury ointment; bearing in mind the possibility of a severe dermatitis if the iodin and ammoniated mercury are used consecutively.

We make a definite distinction between uncured scabies and postscabetic persistent nodules. In a previous communication we reported a failure to find any evidence of acarus scabei or ova in excised nodules,

serially sectioned. In the cases which we reported, continued antiscabetic treatment aggravated the nodules; they were finally cured either by fractional x-ray therapy or by electrodesiccation.

As pointed out by Doctor Chipman, pityriasis rosea may exhibit very unusual manifestations. Occasionally pityriasis rosea may be imitated by an arsenical dermatitis, or by a generalized phytid eruption as noted by Doctor Fanning. I agree with what Doctor Chipman says regarding the relatively slight influence of diet in adolescent acne vulgaris. While it is true that the most rigid and restricted diet may fail to improve a case of acne, I believe, however, that excessive indulgence in candy, sweet drinks, etc., may aggravate the eruption. Certain adult types of acneiform eruptions, or what might be called acne urticatus, are undoubtedly due to food idiosyncrasies of an allergic nature. We have seen several such patients who were relieved by the avoidance of certain specific foods to which they were sensitive, after prolonged x-ray therapy had failed. Cleveland White of Chicago has also recently commented on this condition.

"HEALTH INSURANCE"—PRO AND CON*

BEING SPEECHES MADE AT THE SPECIAL SESSION OF THE HOUSE OF DELEGATES OF THE CALIFORNIA MEDICAL ASSOCIATION AT LOS ANGELES, MARCH 2-3, 1935

Remarks by Rodney A. Yoell, M.D., San Francisco

SPEECH NO. I

Mr. Chairman and Members of the House of Delegates:

I think, without indulging in the usual parliamentary preliminaries that tend to confuse, and without resorting to some of the arts and devices of those that do, I will proceed directly to the subject by discussing the fundamental issues. I think we can safely say that the reason that we delegates of the medical profession in California are here assembled in this city today is to decide the question of social health insurance, and to discuss the care of the indigent as it may bear a relationship to certain aspects of the problem.

I am very pleased, if I may put the personal equation into the situation, to find that there will be opportunity for an informal and frank discussion of the issues, so that when we subsequently meet we will have gone over a lot of the ground and have covered a lot of material, and will be in a far better position to evaluate the recommendations of the committees on any given motion, and finally be in a far more able position to discern the fundamental issues that have been called up here today, and to decide how those issues should be passed upon.

Now, I am going to ask you, for the time being, to forget that you are delegates, but remember that you are citizens and remember that you are physicians. I am going to ask you, for the time being, to lay aside any preconceived notion that you have on the general subject of social health insurance, and sit here with an open and plastic mind and let me submit to you, word by word and line by line, certain thoughts which I feel will convince you that the medical profession has, within today and tomorrow, to take a definite and unequivocal stand in order to do its full duty to the people, and in order to protect its own independence in the future.

I want, first, to call your attention to the genesis of this problem. Anyone who is at all cognizant with the current social philosophy knows that discussion of this phase of the general problem long antedates the present depression. We know that in this State in 1917, some of these very issues were put on the ballot for initiative decision. We know that before the Great War, and since that war, there has been an ever increasing and ever growing and swelling tide of literature not only in the lay, but professional journals, and in sociological works—an ever growing, ever increasing volume of literature in the newspapers and in other publications, all of which point to the fact that the public is certainly conscious of an existing medico-economic situation which demands relief.

Now, I submit to you that, in a country such as this, with an electorate that has freedom of access to the polls so that it may express its every wish when the public and the people comprising that electorate make up their minds to decide an issue, they go to the polls and decide that issue, and from then on that decision, once given, becomes the expressed social wish, and it becomes the law.

Again, I submit that it is imperative, in discussing this problem, to make two diagnoses—the one a social diagnosis, and the other a political diagnosis. The social diagnosis is this: that all trustworthy surveys and studies, including the survey and study made by your own Committee of Five, have proved beyond the peradventure of a doubt that almost 80 per cent of the people of this State have family incomes of $2,000 a year and less, and that 55 per cent of those people have incomes of $1,200 a year and less. It has also been proved beyond any question that all standard prices, particularly in the commodity market, and at a subsistence level which is necessary for a man to support his wife and his average family of two children, must range well above $1,452 up to $1,554 in yearly income. Those figures are the figures of January for this year, based on a study incident to wage arbitration. However, as far back as 1928 Mangold of the University of Southern California made a survey during the peak of the boom, and his figures coincide closely with the figures obtained in the recent study. Now, the point is this: You know and I know that it is absolutely impossible for a family with an income which is just within a few dollars above or below the subsistence level to face a major illness and secure proper health protection without skirting the edge of bankruptcy; that whatever small interests they may have in life, that whatever small equities they have, with the cost essential to an American standard of living, when faced with a major illness they almost immediately become candidates for indigency, and are either forced to put themselves into debt, with the result that they do not get the necessary service or the physician is unpaid for rendering the service, and the hospital is unpaid, and the individual is forced to declass himself, to step out of the self-sustaining bracket and to go into the bracket of the semi-indigent, burdened with debt.

These are the essential facts of this problem. We know that on an individual basis it is absolutely impossible for the average family individually to finance the cost of a major illness; but it is possible, by a coöperative effort, to provide adequate medical care and to protect themselves. The people being conscious of the fact that they cannot accomplish this thing individually, but that they can accomplish it by coöperation, are demanding the right to the coöperative purchase of health protection. What a man cannot do on an individual basis, but can do on a collective basis, if socially necessary, he will do. It is absolutely basic economics that to protect the welfare and livelihood of his family he will use collective action.

There is a parallel to be drawn here from history. I wish to call to the minds of some of you the not too famous name of Tolpuddle. This was the little British village in the middle of England in which the first labor union, in the early part of the nineteenth century, was formed. . . .

Now, we have here today in California an exactly similar situation, an absolute parallel. We have abundant proof that the people of California are demanding the right to the coöperative purchase of health protection, and we have abundant evidence that they are going to have laws passed that will permit them to exercise that right.

In the face of the exercise of that right, the medical profession can do either one of two things. It can either oppose and seek to block the exercise of that right, which would be a gesture of sheer futility, or it can see that, in the exercise of that right, no ex-

* See also editorial comment, on page 473.

ploitation and no inequity is practiced on the profession. In other words, the profession can see that if these laws should come, and if they must come, that they come cast in a mold acceptable to the desires of medicine, not alone with the view of the medical profession's interest, but also in our duty and relationship to the public.

You must remember that we have a degree of doctor of medicine, but we hold a license from the State to practice medicine; and it has always been the tradition of medicine that the profession owes to the public a certain duty. Now, if it can be shown—and it has been shown by survey after survey—that a barrier exists between the family on the one hand, and adequate medical protection on the other, and that that barrier is a financial barrier and it can be drawn aside by the application of the insurance mechanism, if that barrier can be withdrawn in that fashion, then, unless some inequity falls on the profession, it becomes the duty of the profession to seek the removal of that barrier in the interest of better medicine rather than see that the barrier is kept in being. . . .

Therefore, I submit that if all physicians have an obligation to support laws for compulsory vaccination, if we have an obligation to support laws for the sanitary distribution of milk, if we have an obligation to protect the public from fraud or chicanery under the guise of cultist practitioners, how much more have we the obligation to aid the people in the removal of the barrier which prevents them from securing those services which we, and we alone, can give them? It is the sacred obligation of the medical man to remember that we are devoted to the interest primarily of humanity. It is not incumbent upon him, nor is it made incumbent upon him to serve at his self-expense; but if in aiding the people to secure decent medical service he can at the same time destroy a system which operates inequitably unto himself, he has, therefore, a double goal in urging that this barrier be removed.

I could cite case after case from my office calls and from my practice, as you all can, of men with incomes of $120 to $150 a month who have had to place some member of their family within a hospital, and have not only been worried about the pathological condition, and must carry the burden of worry concerning whether that loved one will live or die, but also the added weight of a financial hazard. They are forced to realize that it takes money to let the doctor function as he should.

Now is it the duty of medicine to come to this man, couched as he is in the lap of worry, and aid him in removing the burden that is a torture to his soul? You and I have gone into hospitals, we have gone into the home in the dark of the night, and have seen its anxious family huddled about the bedside of a desperately ill child. And we have known that all the resources of modern science could be thrown into the battle of life in favor of that child if only a sufficient expenditure of money was available. And we have seen, in all far too many instances, that we were hedged and handicapped by the poverty of the family, and we were either forced to serve inefficiently and without just recompense, or else send these people to a county hospital as indigents. In most instances these people are not indigents: it is merely illness that makes them indigent. Is it to be the position of the profession of California to stand up to these people and defend and continue a system which is damnable; to prevent the removing of a removable barrier simply because we feel that, in so doing, certain selfish and presumably entrenched rights might be hazarded?

The public can very justly come back and ask this question: What right of the profession will be hazarded? And we answer in the same hackneyed phrase, "The personal relationship existing between physician and patient." This is no answer, and we know it.

We are faced with a situation here which was very similar to the situation existing in industry before the Industrial Accident Act was passed. We are supposed to know something about the usual order of things, and we are presumed to be able to lead intelligently. I can go back about twenty-five years ago in the history of California and I can remember men in industry who were hurt in industry. . . .

As bad as the industrial act is administered sometimes, in spite of all of its defects, there is hardly a man in this room that will stand up and say that he would not rather have that act continue in being than go back to the conditions that existed in industry twenty-five years ago, and there is not a man who will not accept all the industrial accident work that he can get into his office and on to his wards in the hospital. Now, if a man is willing to accept the check given by the insurance layman before the five o'clock whistle blows, why is it that it becomes unethical after the five o'clock whistle blows? What are the refined sensibilities of the medical man that depend on the time clock? Why is it that a man is allowed to be insured in a commercial organization before five o'clock, that it is quite right and proper that a medical man can care for him, but when that man goes home and falls or stumbles over a chair and breaks a leg the medical profession should say, "You cannot set that leg at six o'clock as well as at five o'clock"? This is an assinine answer. You know it, and I know it. You men who do work for the railroads, you men who do work for the factories, and you men who do work for the mines and foundries all over this State, know that you give as good and sometimes better service to the patients that come to you under the Industrial Accident Act than you do to your private cases, and why? Because you have access to the means of the application of your scientific knowledge that you have not got with a private patient coming from the same status and the same group of population. That is true because the insurance principle makes money available. To say that the patient-physician relationship would be injured by a properly administered system of insurance is ridiculously false.

Now, I submit this: that if this insurance principle is essential and can be applied, and it does not work any injustice to the physician, then whatever tenet by which we hold in our craft as sacred duty, by whatever honor we maintain in our art, we have an obligation to work diligently to see that the people can get, on a coöperative basis, that same service that they cannot purchase on an individual basis. That is the trodden path of our duty, and that is where our fate lies. If we do not do this, such legislation will pass, and then we will be acting under the provisions of a lay commission. What is happening in the State Industrial Accident Commission? Faced by unregulated competition with commercial agencies, subject to chiseling commercial insurance companies, and chiseling doctors, where 20 and 25 per cent of the premiums at the end of the year is paid over to the employer, there is only one method to meet this sort of competition, and that is by cutting expenses; and what is the easiest thing to cut first? There is only one thing that can be cut, and that is the remuneration of the doctor. He cannot help himself. He has no more right to protest such a cut than a member of the crab fishermen's union. And why? When the Industrial Insurance Act was passed, the then so-called leaders in our profession did not write into the Act the basic fact that this was going to concern vitally the proper interests of the medical profession, and with one-third to almost forty per cent of the work coming into the hospitals and the offices of the doctors, it was essential that they should be represented adequately on any board which would administer that Act. Now, having failed under the Industrial Accident Act, when it was forming, to seize our opportunity, shall we, in the face of a similar situation, fail again today? Shall we have these laws passed, as they will be passed, in such a way that any politician from any party can lay the lash on our backs under the excuse of an economic expediency? Shall medicine come before this commission a mendicant and ask simply as a gift from political powers, and not as a right by representation, the fair remuneration of their services and just attention to their bills? Is that the position that we who have gathered from the north and the south and the east and the west of this State, who represent the profession of this State,

representing the man over the drug store, and the man in the country, shall we go back and say we have not committed ourselves?—that we have not the social vision or the social foresight to recognize the importance of this problem, and that we are going to rely upon the outcome of some political experiment for our future independence? If you do, you will find that you will be absolutely a mess of pottage in any camp of political spoilers who wish to gather around the camp fire. Will that be the answer to the men of our profession who pay our expense and honor us with representing them? And yet that is the answer as far as the Industrial Accident Act is concerned. I defy you to show me in any accredited medical journal, or in any medical meeting, any strong plea made in behalf of the medical profession that these conditions responsible for the passage of the Industrial Accident Act be alleviated. We had to leave it to the layman, and now we come out here and say, we who wish to be leaders in social thought, trust us! They have trusted us, and we know we cannot fail them. But we will fail them if with an incorrect social diagnosis we permit individual bias to cloud our reason.

Now, I want to show that some of the material which has been presented for your consideration on the subject has undoubtedly influenced your minds, and that it comes from a very questionable source. In my remarks, I will not indulge in any personalities, because this issue far transcends the importance of any man who is in this room today. It is a matter which is going to demand attention for many, many years to come, and will involve the medical fate of millions of people and the future of an independent profession. I wish to state that some of the evidence presented to you in some of the articles that have appeared in the medical journals have been biased, have been unscientific, have been inaccurate, and in some instances have been false.

I wish to remind you of a series of articles that is being published in CALIFORNIA AND WESTERN MEDICINE. This series began to appear very shortly after this House of Delegates authorized the survey last May. These articles were on compulsory health insurance and were run while your committee was conducting an objective study and an impartial survey. These articles were against any form of compulsory health insurance, and were written by a man by the name of F. L. Hoffman; and these articles, because I have been perusing the literature, contain so many misstatements and so many inaccuracies as regard the factual data that I made it my business to inquire who this Mr. Hoffman was and whence came he, and I am going to submit to you the final report of the Royal Commission of Canada, the province of British Columbia; and in this pamphlet, which I will read to you, there is a direct challenge to the veracity and the integrity of the statistics and figures laid down by Mr. Hoffman when he appeared before the Royal Commission as the accredited agent of the Christian Scientists, and the same articles which appear in our official journal and are at present being published in CALIFORNIA AND WESTERN MEDICINE, are as they appeared in that great journal devoted to the interest of organized medicine, the *Christian Science Monitor* of a few years ago. Now, having gone to that fountainhead of scientific knowledge to give you correct information on this subject, let us turn over the pages of the Royal Canadian Commission and see whether the statements that he made are true or are they not true, and we find this: "At the earnest request of the Christian Scientists, we accorded a special hearing to Mr. Hoffman, and his evidence will be found in Volume 3, Appendix H," and then they say: "A perusal of this evidence discloses, however, that Mr. Hoffman's antagonism to the principles of health insurance is based, not upon any authentic facts relative to the failure or success of the European systems, but rather upon a general argument in condemnation of the principles of compulsory state health insurance. The expressions of Mr. Hoffman are clearly valueless in the light of present-day experience, and indicate that his ideas of European systems have not been brought up to date."

It seems, therefore, that the evidence that he adduced was in some instances between ten and fifteen years old, and the evidence and the studies that were presented in CALIFORNIA AND WESTERN MEDICINE go back further than that. It goes back to 1917. Mr. Hoffman had evidently not followed the latest development of the British system, and I will quote from the British Medical Association, which Mr. Hoffman took issue with, where they say: "Mr. Hoffman also states that health insurance in the United Kingdom has not improved the health of the people of the Kingdom," and they give the figures of the British Government; they published the actual figures from the British Ministry of Relief, and show that there has been a decided decrease in mortality and in morbidity, and they show that the gain has been most marked. In other words, Hoffman's statements were not reliable and accurate, and the Canadian report concludes with this statement: "Mr. Hoffman's criticism was merely directed to conditions which existed more than ten years ago, and which conditions have been steadily improved upon. Finally, we refer to the evidence of Mr. Hoffman in Volume 3, Appendix H, when he was closely questioned by members of our Commission. His evidence reveals, in our view, merely general statements backed up by no reliable facts." [Lays Canadian report on table.]

Now this was the man that was sought out at the beginning of your survey—the paid accredited agent of the Christian Scientists, who have always been the friends of organized medicine and of public health—to educate you on this subject. This was the man that was sought out from the entire length and breadth of the United States as the only man who could inform you as to the merits and the demerits of compulsory health insurance, a man that stood before the Royal Commission and was shown to be biased and ignorant and possibly false, upon the subject that he spoke of. In all of the breadth of this land, in all the surveys made, in all the departments of all the universities, that have spent hours, months and years studying this subject, the one man picked to inform you, gentlemen, and to help you make up your minds as to the value of the plan of compulsory insurance, was the man who represents a group that has always been antagonistic to scientific medicine, and by the very fundamental tenets of his creed always must and will be. That is the type of evidence that you have been influenced by prior to this meeting.

May I submit this, also, that the American Medical Association, knowing that the survey was being made in California, knowing that you people would have to come to some decision, put out a so-called sickness insurance catechism. I shall not point out the inaccuracies contained therein because time is too short, and I do not wish to bore you, but inaccuracy after inaccuracy is contained in that document. Apparently some of the statements of Hoffman are incorporated in that document, and here we see visualized on the stationery of the San Francisco County Medical Association, sent out by the American Medical Association for distribution to the members, active propaganda against health insurance, while we were spending $80,000 to arrive at an impartial estimate of the subject. That is leadership, isn't it?

But this attitude of antagonism and bias goes back further than that, and in proof I will quote some letters sent to the secretary of the California Medical Association by Fishbein, West & Company; and here are a series of arguments that were to be submitted, and the comment is made that since the American Medical Association and its state societies have gone on record against compulsory sickness insurance, it is extremely desirable that the views of organized medicine be made known to the voters; and then it urges that the congressmen who are now with us have political contact made with them in order that the views of organized medicine shall be made known to them. I submit this, as the type of propaganda that was sent out: A series of arguments in which the Committee on Publicity of the American Medical Association said it was not to be let out that this comes from their committee, because that would bias and prejudice

the public. In other words, they were afraid to get out in the light, but this was behind the screens when they expressed themselves, and these arguments are all against the principle of compulsory health insurance, or a sound system of social relief insurance of any character. Now, if we remember that this is the sort of material that has been handed out for your consideration, it will undoubtedly be extremely difficult for some of the delegates here to keep an open mind; but I wish you to remember, inclosing, certain irresistible facts. They cannot be escaped from! The first is that there are four bills in the Senate of the State of California calling for a social health insurance act. There are four counties in this State that have elections for proposed new charters which makes it absolutely mandatory on the supervisors to receive any resident of the county who wishes to come into county hospitals, irrespective of his personal income; in short, that any person be admitted to the county hospital. There is also the question of an initiative on the part of the Epic people, who wish to put on the ballot of this State the question of throwing open the county hospitals. In other words, there is an organized effort to make a Kern County of the entire State of California. And we have been told, on two occasions, by the Interim Committee that they expect our leadership, and that if we come in with a fair bill they will recognize the edicts of the profession. They are down in writing as to that, and they have also expressed themselves privately.

Now what shall the attitude of medicine be? Shall they go ahead and support a system of voluntary insurance which has always failed? We can talk about that later. Your committee was instructed to bring in a plan and a bill, and the proponents of the voluntary plan have not one shred of evidence showing that there is anything more than a plan of a nebulous welfare bill. There is no plan presented in the majority report of the committee. There is a general outline and a statement of principles, and there is the hopeful wish that legislation, which might make this fanciful proposal possible, could be gotten through, but there is no provision in the Assembly or in the Senate to provide that legislation nor any hope of getting any.

Our opponents talk about political domination under a compulsory system. We who do some industrial practice are subjected to a competitive lash far worse than the sting of political domination. We have, under the Industrial Accident set-up, no right to representation on the administrative board, nor can the Commission regulate cut-throat competition offered by certain commercial companies against itself. These companies can reduce the premiums offered to industry because they can get chiseling, pandering doctors to work for them at fees below the rate granted by the Commission, and thus underbid any decent fee schedule.

Unless some sane legislation is worked out preventing a repetition of this reprehensible and unfair system, it will carry over into measures intended to care for the health of the mass of the whole people whether industrially insured or not. If collected efforts are to be directed against the hazards of illness, let the laws providing such a system be soundly drawn and let us aid in framing them.

If the county hospitals are going to undertake the task—and apparently they are—and if we let them succeed, we shall have a system of State medicine intolerable in its viciousness. We have had our bitter experience in Kern County and other counties, and the men here from those districts can testify as to that sort of politically dominated competition.

So, before we make our final decision, remember three, and only three, points: that there is an economic need and that this need will be answered by the people; that there is the right to the coöperative buying of health protection, and people will exercise it and write it into the law, and that the medical profession has one objective—to protect itself in the writing of such a law, and in insuring, in the enactment of any system, a legal and recognized status that will forever prevent its exploitation. If we agree with these essential points, let us take a position in favor of a mandatory system of health insurance, with technical control in the hands of the profession and the control of any pool of wealth from which funds are used to furnish medical care under the direction of a commission. Then medicine will thereafter be free; but if we do not do that, we will fall under the bureaucratic system of State control, and will be given over unto the commercial groups, which can buy and sell our services like chattels. We have our choice. Let us make our decision wisely!

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Remarks by John Hunt Shephard, M.D.
San Jose

Mr. Speaker and Members of the House of Delegates:

The terms "state medicine" and "health insurance" are not synonymous, and we should be very careful not to use them as such. Fundamentally and basically, they have very little in common. State medicine is a system of providing medical service for part or all of the subjects of a political unit, administered by political employees, the expense of which is defrayed in whole or in part by funds derived from some general or limited tax levy; whereas health insurance is the conversion of an indeterminate, unpredictable loss resulting from sickness into a determinable predictable expense borne by the individuals who may derive benefits therefrom.

In other words, State medicine is paternalistic, providing in whole or in part a necessity for certain classes at the expense of other non-beneficiary classes. State medicine is exemplified in several European countries, but we do not have to go abroad to see the inequities, injustice, and incompetence of such a system. We only need to view our Veterans' Bureau, furnishing medical hospital service for non-service connected disabilities, to get a clear picture of this unsound and ill-advised system. We do not have to leave our own State to study the workings of health insurance. We find the principles of insurance being applied in the furnishing of medical and hospital care to the employees of several large corporations. The potential beneficiaries pay the cost. The service rendered them is of a superior quality, and those rendering the service are adequately compensated without waste, extravagance or graft.

For eight years, in association with two other doctors, I was engaged in similar health insurance work in northern Idaho. The various employers made wage deductions from the employees, turning the same over to our organization. We furnished unlimited medical, surgical and hospital service for the sick and injured employees. We delivered excellent service and received compensation equivalent to the then prevailing private practice fees. The only dissatisfied or disgruntled individuals were a few competing doctors who claimed it was unfair competition, and I agree with them. This was compulsory health insurance, and was the most pleasant and satisfactory practice I have ever enjoyed. At the height of our business, we had over six thousand employees under contract. At one time we attempted to establish a group under voluntary health insurance. We had established the reputation for giving highly satisfactory service; we were personally known to practically all of the residents and served over half of the population in that vicinity who were not under contract with us. We advertised our voluntary health insurance plan in the newspaper, by posters in the sawmills and logging camps, by posters in our offices, by word of mouth and by personal solicitors, but were unable to secure a large enough membership to make it worth while. Only a few of the married men under contract with us would subscribe for a voluntary membership for the members of their family. Their incomes were small, 25 cents per hour being the basic pay for common labor at that time, and the monthly premium necessary for us to assume the risk seemed unsparable by the majority. However, when members of their families required medical service, the percentage who paid for the same was as high or higher than the same class of workers today.

From this personal experience, under most favorable circumstances, I do not believe that any voluntary health insurance plan will be largely patronized by the group of people mostly in need of it, and if a solution of our present difficulties is to be found in any form of health insurance or State medicine, it must be through a system of compulsory health insurance.

There is much discussion regarding what economic group should be included under any system of health insurance. Some claim it should be limited to those earning less than $2,000 per year. Others set the limit at $3,000 per year. Personally, I believe there should be no limit. If we endorse and work for a plan of health insurance, it must be as nearly ideal as can be conceived. To me, that means a plan providing complete health service, preventive as well as curative, for every individual from birth to death. I fully realize that it would be poor judgment and would probably result in complete failure, if we attempted initially to institute such a complete plan, but should we not have the entire picture in mind when laying the foundation?

Today we are making the "have's" pay for the "have not's." We are serving many whom we do not charge, and many more who do not pay us, but those from whom we do collect are paying for what we like to speak of as our "charity" service. If I could be paid a modest sum for the services which I render to the low-income group, I would gladly forego the occasional large fee that I receive.

We must look upon ourselves as the functioning part of a public service and, as such, make our services available to all, not by gratuitously serving one and excessively charging another, but through some means or plan whereby each self-respecting, independent individual, can provide through his own efforts adequate medical service for himself and his dependents; and compulsory health insurance, under the control of organized medicine is, I believe, the only answer.

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Remarks by A. R. Kilgore, M.D.
San Francisco

Mr. Speaker and Members of the House of Delegates:

I think we are all agreed that a policy of *laissez faire* will not do. A definite economic problem has grown up in this country of financing the care of illness for the low-income group. It is not a problem of the depression. It existed before, and has only been made more acute by the economic situation. Where there is a real social problem, the solution will sooner or later be found; and I am quite in agreement with other speakers that the only final solution to that problem is health insurance, and even in agreement that eventually it will have to be compulsory health insurance.

But the central consideration which we ought to keep in mind is that, for the success of any such system, there must be medical control. And we ought to think more clearly than some of us are thinking about medical control. A medical control, consisting of management by politically appointed doctors of medicine, would not be satisfactory to me and should not be to you. A control limited to the establishment of standards of practice, of the discipline of doctors, and not extending to control of the compensation of physicians, control of the income limits of the people to whom insurance is to be offered, etc., will not be a satisfactory control.

Anyone who has read the history of health insurance abroad must be convinced that just to the extent that medical control has been preserved by the organized profession, just to that extent have systems been more or less successful. Where medical control has been lost, and the systems have been operated under management by lay groups, either government or private, the service has been unsatisfactory to all concerned.

Now, what chance have we of getting the necessary control if compulsory health insurance is adopted today? If you talk about medical control with lay people, you will be surprised to find that our argument does not appeal to them. For us to attempt to gain complete medical control of health insurance sounds to the layman like an attempt on our part to set up a medical trust and dictatorship. It is difficult for the layman to understand that medical control is necessary for the satisfactory working of the plan to the people whom it is going to serve.

Even in the Advisory Council to the California Medical Association's Committee of Five, well-informed as these gentlemen are, the idea was very strong that the control of compulsory health insurance should not rest with the medical profession. They are willing enough to place somewhere down the line a medical advisory committee or a medical director, appointed by the political governing board, charged with the maintenance of medical standards and the discipline of doctors, but they are not willing really to turn the plan over to medical control. Even Doctor Yoell, whose bill a few weeks ago called for a majority of physicians on the governing board, now asks for two physicians out of five members, not appointed by the California Medical Association or even nominated by it, but from a list supplied by the board of regents of the University of California. Perhaps no more impartial body could be found in this State, but it is not the organized medical profession. And even at that, Doctor Yoell is asking for two doctors on the board, not hoping to get the bill written and passed in that form, but expecting to use this request for bargaining to get whatever shreds of medical control can be obtained from an unwilling legislature.

Think of the amount of money involved. With a million and a quarter employees in industry, plus their dependents, between fifty and a hundred million dollars a year would be collected and spent. Do you suppose, for a moment, that you can keep the hands of a group of politicians out of a fund of fifty million dollars a year?

Speaking of money, let us ask ourselves, before we endorse compulsory health insurance, what the costs of administration under a politically controlled set-up will be, and where these costs will come from. Go to the British plan and find that a little more than 50 per cent of the amount of money paid to doctors is the bill for administration. That money does not come from tax funds. It does not come out of thin air. It comes out of money that ought to go for medical service to the people, and it comes out of the compensation of the doctor.

If you want an example of what happens to doctors' money, look at the experience of our Board of Medical Examiners and its fund of $200,000, built up from examination and registration fees paid by us, and later used in part to aid in the payments due on a San Francisco office building purchased by the State.

As I said a few minutes ago, the argument for medical control is clear to us, but does not appeal to the layman, and there is very little use of our making it. But there is a line of perfectly clear and logical reasoning which should appeal to intelligent laymen. If we are going to establish health insurance, we want to set it up as nearly right as we may. Some mistakes in any law will require correction, but we ought to make them as few as possible, because mistakes under legal enactment are not easy to correct.

We cannot use a foreign system like the British for a model. A service limited to care by general practitioners would not and should not be satisfactory to Americans. The problems of organization and administration become infinitely more complex when to care by general practitioners is added services by a complete organization of specialists, to say nothing of adding hospital care as well. I could cite in detail many of the problems presented without being able to furnish answers to these problems. Only experience will tell us how they should be solved. The early years of operation of a health insurance service will give us an enormous volume of information which can be obtained in absolutely no other way.

It seems to me perfectly reasonable and fair for this Association to say to the State of California that we think no one, ourselves included, knows how a compulsory health insurance law for California should be written. Therefore, as a part of our obligation to the people of this State, we want to work out in practice

many of these difficult and complicated problems before the final law is written. And we will do this on our own responsibility on a voluntary basis.

We have heard a good many times that voluntary insurance has always failed. It may not have taken in as much of the population as should be insured, but one can hardly say that the railroad and other great commercial organizations operating health insurance for their employees have failed. We may not approve of some of the commercial health insurance organizations in California, but we can hardly say they have failed. We have seen very little experience in the operation of health insurance by the organized medical profession, but the one plan I know of in operation—that operated by the King County Medical Society at Seattle—has not failed. It is insuring 21,000 industrial employees (all but five per cent with incomes less than $100 a month) and paying to its doctors a substantial sum of money in medical compensation, most of which they would not receive except for the insurance machinery. They have made mistakes and learned many lessons, but since their plan is one of their own they have not had to go to the legislature to correct errors.

I should go one step further in our declaration of policy. I should like to see us offer to work out the problems of health insurance in the school of practical experience on our own responsibility. But we should also say to the Interim Committee of the Senate that if, in their opinion, the temper of the people and of the legislature is such that they must introduce a compulsory plan at this session, we will sit down with them and help them write that plan in accordance with principles which we adopt at this session.

I want to leave this thought with you again. The essential fundamental for a successful plan is medical control. Control goes with financial responsibility. If the State assumes financial responsibility, it will assume control. If we want control, at the present time we must be willing to assume responsibility. Which alternative would you shudder at most—assuming a financial risk or giving up now forever the control of medical practice by the organized medical profession?

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Remarks by Dewey R. Powell, M.D.
Stockton

Mr. Speaker and Members of the House of Delegates:

From the resolutions that have been presented and read at this session, and from the discussion which we held yesterday and which has gone on this morning, there is ample evidence of a very decided difference of opinion as to the questions at issue. I am very much surprised that there are still a few of our number who believe that we can sit back in smug complacency and continue the present system. This policy of *laissez faire* is a surprising one to me, and how anyone can expect that the medical profession can continue on in the present *status quo* and remain unruffled and uninterested, as many have been, in changing social conditions and changing public opinion, is beyond my conception.

I have the highest regard for the profession in which we are all engaged, and none has a keener appreciation of the achievements of the past. If I had to do it all over again, in spite of the cares and the worries and the trials and the vicissitudes, I would again elect to study medicine and enter upon its practice. Yes! I have as high an opinion of our profession as anyone, but we in San Joaquin County, gentlemen, have no delusions of grandeur as to the place that our profession holds in the public mind. We have ample evidence that we have lost much of the prestige that formerly was ours, and we must zealously guard the place—a high place, I am happy to say—that still remains to us in the social structure of this State. But this problem that we are discussing today concerns not only ten or twelve or fifteen thousand members that are practicing the healing art—it concerns virtually some five million of our lay population; and while the interests of our profession must be adequately safeguarded, let us keep in mind that our primary duty is to the public at large. I believe that I can safely conclude that the great majority, even a two-thirds or three-fourths majority, concur that the policies of doing nothing, that *laissez faire*, have no place in our deliberations today. We must formulate and express a public opinion. We owe it, gentlemen, to our members back home that are awaiting the result of our deliberations here today. We owe it to those younger men in the profession who face the future. We owe it to those boys, perhaps some of your boys, who are in medical school or in preparation therefor, and who expect to continue on in our footsteps, and we want to give to them the heritage of a professional unhampered by lay restrictions and by regimentation. We must not evade the issue, but with clear thinking and with shoulders erect and head high we must take a long view perspective and formulate an expression of which we may well be proud.

Now, what alternatives are open to us? We can agree that we must utilize the insurance principle of periodic payments to meet unexpected and unpredicted risks and expenses. We have two alternatives under the insurance principle. We can vote for the resolution under discussion, in favor of the voluntary plan. But let me point out to you that by their own admission they, the proponents of this plan, admit that it is inadequate. They state that at the present time we can only take up the matter of hospital insurance. And I ask you if you gave to us, the delegates of San Joaquin County, the right to establish, under the authority of the California Medical Association, a system of voluntary hospital insurance in San Joaquin County, how could we compete with a county hospital finely equipped and wide open, admitting any citizen of the county, irrespective of his financial status, free of charge? How could we sell such a voluntary insurance? Gentlemen, it would be absurd to broach it to the profession or to the public of San Joaquin County. I, representing the San Joaquin County Medical Society, presented our viewpoint to the County Board of Supervisors not long since, and the chairman of the board (who I know holds me in highest personal regard) said to me: "Doctor, if you have any idea that the policy of this board does not adequately represent the great majority of voters of this county in the policy maintaining a wide-open county hospital, we shall be very glad to place the issue on the ballot at the next general election." Did the medical profession of San Joaquin County accept that challenge? Gentlemen, we know better. We should have been defeated, ten to one, had it come to expression of opinion at the ballot-box. A system of voluntary insurance is so far inadequate as to be pathetic. By their own admissions the proponents of voluntary insurance state that enabling legislation will be necessary before it can include the all-embracing medical and surgical care. Have you read this supplementary report which Professor Dodd's survey staff submitted to the Committee of Five that was passed to us yesterday? Do you recall a sentence therein that there is no assurance that such enabling legislation could pass, because it might well be interpreted in the nature of a monopolistic control on the part of the California Medical Association, and might well stir up a hornet's nest of opposition to present it to the legislature? There is no assurance that such enabling legislation could be passed.

Voluntary hospital insurance again would necessitate the California Medical Association entering into the insurance business and obligating itself in a financial way, which might lead into stupendous and uncertain amounts. And I am here to say to you, gentlemen, that many of you who desire adequate voluntary hospital insurance shudder at the thought of members of a scientific organization, primarily dedicated to the advancement of science, exchange of ideas and the better understanding of our own profession, entering into the field of finance and insurance and obligating themselves and the funds and the surplus that we have built up over a long time to this new venture in which we have had no experience, and the costs of which are most uncertain. Yes, I think I can say that we all

shudder at the thought of assuming such a financial obligation to the people of California.

Again, I will call to your attention that the voluntary systems of insurance have never worked successfully on a large scale, while on a small scale the degree of success attained has been due almost directly to the proportion of compulsory features that they contain, particularly in the selling end and the collection of the premiums. Every voluntary system, gentlemen, has been an entrance wedge of only shorter or longer duration toward the inevitable solution of compulsory obligatory insurance. Therefore, we must turn to the second possibility, the question of compulsory health insurance; and if we are to reach this group in the low-wage brackets needing it so badly, if we are to protect the profession and the community against the improvidence of those who are unfortunate or irresponsible, if we are to put it on a broad financial basis with a proper spread of risk that will make it insurable, then that system must be compulsory. But, gentlemen, one of the resolutions that has come up hereafter takes even a broader view, to which I am willing to subscribe: that we can very easily recommend a system mandatory for some groups and voluntary for other groups, and with our committee in conference with the Interim Committee of the Senate work out a system which will safeguard the interest of the profession and meet the problem at issue.

I feel that our profession is to be complimented as to the confidence which this Senate Interim Committee has placed in us, for we have their assurance, both oral and written, that they will accept our plan with a great deal of sympathy, and will earnestly coöperate with organized medicine in this problem. So, gentlemen, we cannot simply mark time. We cannot delay the issue. The legislature reassembles tomorrow. The Senate Committee is waiting for an expression of opinion. We must not evade the issue nor hedge. Let us instruct from this House of Delegates today that a committee be delegated to confer with this Interim Committee and form a system protecting and safeguarding the profession and offering mandatory insurance, obligatory or compulsory, if you like, to certain groups of our population, and voluntary to others. I want the privilege, gentlemen, of returning to my home in Stockton, and there tell my fellow doctors about my confrères in this convention, tell them that the majority of the practitioners of this State, as represented here in session, have a broad viewpoint, and a long-time viewpoint; and that they recognize the necessity of changing conditions and the changing social structure. And I want to tell them that we have instructed our committee on broad lines to meet the problem at issue. I want to tell my boy in high school, who is looking forward with pride to following the tradition of the practice of medicine, that we are going to do something for him and his pals by saving the profession from lay control and regimentation.

Gentlemen, I have confidence in the unexpressed opinions of those here in this session who have said little and thought much. I have confidence in your judgment.

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Remarks by Daniel Crosby, M.D.
Oakland

Mr. Speaker and Members of the House of Delegates:

This is not to be a discussion of personalities, but I cannot come before you without expressing my deep respect for the industrious study of this subject made by Doctor Yoell, even though many of us are unable to agree with his interpretations or his conclusions.

We have various interpretations of the success of insurance measures abroad, but even the most enthusiastic must realize that European psychology is not transplantable to California or to America. We must weigh the problem as it faces us, and determine whether a health insurance statute upon our book—with our present understanding—can offer a constructive solution.

The earning power of the doctor cannot enter seriously into this question. Service to the community is paramount, and earning capacity or the lack of it cannot constitute an argument for a health insurance act.

But the earning power of the people of California is greatly to be considered. Our tax bills are mounting, and wherever health insurance laws have been enacted the tax burdens have greatly risen.

California, in 1933, faced an enormous tax burden. Here are some of the figures: California produced from petroleum $143,000,000; from manufactures, $83,000,000; from the citrus crops, $50,000,000; from other orchard crops, $102,000,000; and from other field crops, $160,000,000—a total of $465,000,000, or $125,000,000 less than our present tax bill.

Rapidly mounting costs, the notoriously inadequate information submitted to all of our legislative bodies, the absence of significant criteria in our own land, the well-recognized complications in the health insurance structures abroad—although these last are so commonly minimized by our self-appointed, enthusiastic, crusading guides—are probably among the significant items which have prompted the none too conservative Madam Perkins to announce: "There will be no hasty legislation in the matter of health insurance."

Even the President, in his New Deal enthusiasm, hesitates about coming forth with a health insurance program.

We are in the midst of economic puzzles that confront the universe; the medical problem is but one of these, and we must not dare let ourselves be led into the quagmire of ill-considered health legislation in the hope of creating a panacea.

Unbridled enthusiasm can nullify the effect of the most industrious investigation; and when flamboyant oratory becomes the motivating force in driving home conclusions based upon ill-considered data, we are reminded of the saying of Montesquieu: "I love the peasants because they have not been sufficiently educated to argue erroneously."

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Remarks by Nathan G. Hale, M.D.
Sacramento

Mr. Speaker and Members of the House of Delegates:

I had no intention this evening of coming before you and presenting any argument on the subject. My oratorical neighbor, my good friend Doctor Powell, presents a case that, to those in the neighboring counties, has been a source of worry for years. Doctor Powell has presented the facts in San Joaquin County, but he has not presented the desirable facts as they relate to the private physician who has no control over the San Joaquin County Hospital. There are doctors in San Joaquin County who feel that such a situation has been countenanced so long that at the present time no other method is available; and in my opinion no other method ever will be available for any medical group so long as you present a charity hospital to the Supervisors without supervision of local county medical units, with proper care of the patient as their primary motive.

As vice-president of the Chamber of Commerce of Sacramento County and the chairman of the Public Health Committee, I have, for a period of three months, been making an economic survey of their public health situation. We have collected statistics, through the aid of the Bureau of Vital Statistics of the State of California and at no expense to the State, which present an entirely different aspect to this subject. In order to set forth the health situation, one has to investigate temporary poverty not only as it relates to the State of California, but in each individual county. For instance, in October, 29.9 per cent of the population in Los Angeles County were on temporary relief, while in some of the counties in the northern part of the State the temporary relief is less than one per cent; which means that the burden that is placed upon the taxpayer is a great deal more in those counties that have not been improvident during the good times as compared with those counties that have been improvident, if the taxes for such are distributed in a state-wide manner.

The Sacramento Committee on Public Health was chosen by the Chamber of Commerce of that city to represent every group—an osteopath, a leader of the Church, a member of the school department, a dentist, and an optometrist, etc. After being passed as satisfactory by the board of censors of the County Medical Society, a report was unanimously adopted. It was then presented to the board of directors of the Chamber of Commerce, composed of twenty-one prominent men representing the city and county of Sacramento. The Chamber of Commerce directed that copies be sent to as many of the lay people as we wished, and to our representatives in the legislative body. The member of the Health Committee who was in charge of the public schools asked that mimeographed copies be presented to all the teachers in Sacramento.

I believe I am safe in saying that we shall never get away from individualism in this country. I do not care what Europe does. After all, we are not following the policies of Europe, and we have not since we dumped the tea out in Boston harbor. The question is, necessarily, whether Sacramento County is doing her share in meeting the present emergency in caring for the sick and the percentage of financial distress in Sacramento County, as compared with distress evidenced in other like communities.

With your permission, I shall read some paragraphs from the report to which I have already referred, in the hope of adding emphasis to some of the matters on which I have just spoken.*

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Remarks by Harry Wilson, M.D.
Los Angeles

Mr. Speaker and Members of the House of Delegates:

. . . We are all aware of the fact that the care of sickness is the sixth industry in the United States, and such an industry is open to exploitation; that 125,000 doctors of medicine are desiring to maintain a position of control in comparison to 875,000 lay or technical associate workers who are helping to render care to the 120,000,000 people, and who are a little disinclined to see the control remain in the hands of the medical profession; and that there are other interests which have been busily at work in this country for quite a few years, long before this period of depression, in an attempt to foster theories upon this country, following the precedent in other countries of the world that do not happen to be so fortunate in their financial position.

Fundamentally, I am a nationalist. It is intolerable to me to think that we need to lower our standard of living to compare with that of India, China and central Europe, and change other social ratios and working conditions to conform to some of those less fortunate countries. It does not seem that the cry for a change is coming from the medical profession. I think we have been susceptible to the influence and the pressure that has been brought to bear upon us. If you look back for only a few years you will realize that the Costs of Medical Care Committee, funded by persons who had a definite, preconceived plan and purpose but were not interested in the factual data developed in the study, brought that report into being and brought the committee into being in a time of unprecedented prosperity. Then, realizing that they had made a mistake in tactics, they shifted the attack to public news items and propaganda to bring us into subjugation that we might conform to their ideas.

Unfortunately, I am sorry to say your Committee of Five has been guilty, in my opinion, of expending $32,000 of your money and $56,000 of SERA money, funding a study that has been devoted to the publication of the expressions of men who had similar preconceived ideas. The report of the Advisory Council that has been submitted to you, the preliminary and supplementary report, is not the report of the Committee of Five of the California Medical Association. It is the report of the Advisory Council and of the staff. Most of the opinions expressed have been the opinions that each of those gentlemen have held for some few years. They are based, in my opinion, not upon the data assembled, but upon social theories that have been held and are being taught by academically minded men who are not living in a life of reality, so far as going out and selling their services in the commercial competitive field is concerned.

To my mind, this is a problem of theory versus practice. All of us are susceptible to the expressions of theory. They read well, but when we attempt to adjust those social theories to the actual practice of submitting them to a politically controlled mechanism, with other than professional men in the saddle, with lay hands on the reins, who may not be actuated by the same altruistic theories and feelings that cause a man to select medicine as his field of endeavor, then we are up against a real problem of practice; and practice and theory do not often work well together. Even Marx stated years ago, when he gave expression to his theories, that it would be centuries before, in practice, they could be found acceptable.

Now, I think the medical profession is willing to participate with society in a change of living conditions, provided we participate as a unit along with other units; that we are not selected and our services will not be the only services made subordinate to lay commissions appointed by the Governor, and subject to change by each incoming legislature every two years, with the injection of the lay mind, instead of a group of doctors, as the dominating factor as to what constitutes good practice. Most of us are fairly willing to be told how to do a scientific act in medicine by a man of our own field of endeavor who is better equipped than ourselves; but most of us are rather decidedly opposed to be told by a Ph.D., or by a poorly trained individual who assumes a knowledge that he does not really possess, how to perform the practice of medicine. Medicine is only about fifty years old in its modern conception. We have had the daring to conceive many new things in spite of the fact that the medical profession are ostensibly a conservative group. Properly so. I told Mr. Edwin E. Witte, executive director of the President's Economic Security Committee, in Chicago, that if there was any criticism of the medical profession for an apparent unwillingness to coöperate with his committee in solving the social problems, he must remember that he is dealing with a conservative profession. If we accepted every nostrum for the sure cure of the illnesses of mankind, as well as correct advice of some of the gentlemen who would like to tell us how to practice, the useless, harmful drugs that would be forced down the throats of the defenseless public would be comparable to the social abuses that compulsory health insurance will bring to all of us.

I think that we need to have courage in handling this problem. We are not "defeatists" in this country. It is inconceivable to me that we should throw away in one move a heritage that has allowed us to attain to a cultural development with standards of living that have not been reached by any other nation in any other part of the old world. I do not see why we should subordinate ourselves to theory, rather than to have the courage to stand up and fight for the things that we believe in our hearts are fundamental to progress. I do not think that there is a man here, if he would face the fact, but who believes that compulsion is injurious to the field of medicine, and that we are not going to subordinate the practice of medicine to lay commissions. If we could write the most perfect bill in the world and then trade it off on the floor of the legislature, when we got through with the best trades with industry, the cultists, the hospitals, and various other groups having different concepts of a perfect bill, and if we excluded the voice of patronage and the political manipulation involved, we would all come to the same conclusion: that the public welfare of our patients in the future will not be served better. Any comparison to European precepts of health, and so forth, will not help us in our problems in this country. Any betterment over there is a step forward in those countries.

* A digest of this article was printed in the April issue, page 241.

Now, just what does legislative enactment mean? It has been stated today that we can secure forever medical control of standards. I do not know of a provision of government that is perpetuating, that is going to prevent the Governor from leaving off the two possible medical men of the Commission. There is no restriction on the legislature or the vote of the people by use of the initiative for the perpetuation forever of professional control. Forever, stretched over two years of time, is an abuse of poetic license, it seems to me. You know the usual fate of legislation. There is no use enlarging on that. You know the difficulty we are going to have if we turn this bill over to the Legislative Committee and the difficulties that committee is going to have in trading and attempting to maintain the things we want, in the face of an almost unanimous opinion of our Advisory Committee of economists, who believe it is against their best interests to permit us to have as a class any representation upon the Commission. They cannot see why the doctors of medicine should have any representation. It is true, as a matter of political expediency, they have shifted their views, and with it their recommendations on paper as submitted to us in order not to permit their recommendations to be rejected, just as Doctor Yoell has submitted a final draft, and he varied it from the original draft; and the original one, I am sorry to say, compared almost word for word, and provision for provision, with the Epstein Compulsory Health Insurance Bill that has been submitted to many of the other states in this country. Whether the suggestions and advice were heeded at that time, or whether the changes were for the purpose of political expediency, I do not know; but those are the facts.

Now, the actuarial estimate. It would be rather desirable for us to know how much of a fund might be built and divide the fund into the various figures. I am sorry that the committee is grossly lacking on any report on the actuarial status. It is true, I believe, that none of the insurance companies have been willing to underwrite health insurance if service was rendered. I heard William Shepherd of the Metropolitan Life Insurance Company (who, I imagine, is an authority on this subject and has a tremendous amount of information available) state that it was probable that the costs of this insurance might be an actuarial undertaking, but it was one of the least known of the insurance problems.

As a lay actuary, and hoping to bring to you some little vague study of what might happen to us if we submitted the care of the people to compulsion, I have broken down several figures. I have taken first the statement rendered to us by the survey staff that there were approximately 1,300,000 workers in the State of California who would come under the provisions of the insurance bill that has been presented to you by Doctor Yoell. One million three hundred thousand workers at $60 per year, $5 per month, and that is a rough approximation of the probable percentage of the proposed minimum written into the bill. That would produce a fund of $78,000,000, less the administration charges; and I include only $6,000,000 for administration charges, whereas, if the costs are anywhere near average, it would be $12,000,000. However, allowing $6,000,000, there would be $72,000,000 left, and dividing that by three—because it has been fairly well demonstrated that out of the $30 per capita cost to render care in sickness, a little less than one-third of it is available for professional services, that is, for the doctors of medicine—would leave a fund of $24,000,000 that might be available for professional services. Counting eight thousand doctors in this State (and that is an unfair figure to use, because any bill that will be passed will undoubtedly include also the physicians and surgeons who have degrees of doctors of osteopathy, and it is barely possible that even those who have licenses to practice chiropractic will force their way into it) and taking it in its best comparison, counting only the eight thousand doctors who are eligible to serve under this bill, and dividing these eight thousand into the $24,000,000, we find a gross annual income of $3,000. It costs 50 per cent to practice medicine, so the net potential income would be $1,500 per year per doctor out of 50 per cent of the paying population, without any provision for the dependents and taking only the workers, leaving some 20 per cent of the population in the indigent class and the bracket just above which would not be provided for in the insurance plan; and considering that the exemptions are slightly less than the workers who have been insured, you would be forced then to attempt to extract from the 19 per cent of the population that come above the $3,000 a year class the rest of the costs that you are going to live on, take care of your families, educate your children, send them, possibly, to medical schools and make doctors out of them; and that would mean that 400,000 persons (adults who are income producers) would have to pay more than $200 per year in order to bring to the doctor the potential income of something less than $2,000 per year net. . . .

It is obvious that a fee schedule of costs, about 50 per cent, will be the standard fee schedule that will likely apply to the remainder who are able to pay cash. It is also obvious that the returns are going to be so slight and so disappointing that there are only two or three inevitable results. The medical profession is going to have to do as they are doing in Great Britain—join federations of labor and labor unions. We will, without any question, have to become a very prominent political body, coördinated, not varying and differing in our ideas, not a profession set apart, so that we can be exploited in groups instead of dealing with the problem as a profession. It would seem to me, in the adjustments that must follow, we as a profession shall be forming labor unions and aligning ourselves with other employees—and there is no use kidding ourselves that we are not employees when we accept from the fund, pay in units. It is immaterial whether we get it in units or a pay roll by the month on a salary basis, we shall be accepting our orders from the lay supervised controlling staff. I do not think any of us are fatuous enough to think that we can maintain professional control under our present conception of legislation. Then we will be forced into the position of using strikes in order to enforce our rights, and of fighting for our rights in the adjustment problems that will follow. A profession with an altruistic motive, faced with the inevitable necessity of walking out of charity institutions in order to bring boards of supervisors and county representatives into line to make available to us fees for this large group of people, the indigent, who are presumably also not receiving adequate care; or at least of bringing about an adjustment whereby we as professional men may share with the community some of the financial responsibility or allow them to share with us some of the financial responsibility for remuneration for professional care.

I am of the opinion that it is good medicine sometimes not to operate, if your operation is going to kill the patient or make him really worse; and I am frank to say that I have approached this problem with a good deal of humility, without preconceived ideas, and I have attempted throughout this entire study to wait and see if some good could not come out of it. I myself am fundamentally not a "defeatist." I believe that we have the courage to stand up for our rights. I think we cannot compromise medicine for political expediency here today as to what we conceive to be the best interests of the people in order to meet an apparent demand, and even if we get compulsory health legislation forced upon us by the people, we are in a stronger position when we get through if we stand by the principle that we believe that individual service by the physician is the only safety of the welfare of the people. And today I hope that you gentlemen will have the courage to insist and stand together for withdrawing the hastily conceived, improperly presented plan, not based upon factual data but based entirely upon theory, and based upon a precedent that has proved to be an unhappy experience in every country in which it is being tried, where the medical profession has been degenerated into living conditions under which they render their work that is intolerable

to us. I do not believe the profession in this State, assuming the responsibility of being chosen as the weakest line in defense in national concepts, are going to fail in their duty to support the profession throughout the United States in standing for our principles rather than being subjected to exploitation.

The committee report recommended that a plan be made available that can use any mechanism that might be selected: it is immaterial to most of us whether it is a copartnership, a limited insurance company, a trust-fund mechanism, or any other mechanism that might be selected through a proper study by legal counsel. It is immaterial whether the plan actually receives a large support by voluntary contributions or not, because we as a profession will continue to take care of the people as they present themselves to us for care, and we do not need to worry as to legislation at times when the factors are decidedly against the best interests of the people, and there is an element of hysteria on the subject of social legislation. The plan was presented, not with the thought that it would be an overwhelming success. It was presented with the thought that we would have a mechanism available representing the profession that would, through organization, render or make available the services that we as individuals have been giving for centuries, and will continue to supply for centuries.

So I must heartily endorse and ask you to support the committee's recommendation that we do not go in for compulsory insurance. Also that we have available a mechanism that will, through organization, make care possible. If the national concepts of social adjustments develop along the lines on which they now seem to be unfolding, and we have some federal intervention with State legislation which will recognize the profession as a group, we shall be able to more fully declare our rights than will be possible under our present legislative set-up.

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Remarks by C. A. Broaddus, M.D.
Stockton

Mr. Speaker and Members of the House of Delegates:

. . . A lot has been said about the people's free choice of a doctor. I think they should have that free choice; but the people are not so concerned as to who the doctor is, so long as they get him for nothing. When I first came into San Joaquin County some ten years ago, the most talked-of man, the most outstanding surgeon, the one in whom the majority of people had confidence, the one for whom they would have lain down on the table and let him cut off their heads (if he said that was the important thing to do), was the medical superintendent of our County Hospital, and they got his services for nothing, as far as they could figure it out. That man has continued to have that reputation, and he has it today out at the County Hospital; but he tried to move into town and open a private office. He did not cut loose from his County Hospital salary of $7,500 a year, while first waiting to see if he could succeed as a private physician. The competition in private work has not been very serious in Stockton from this man, although he has a wonderful reputation because he worked for nothing out in the County Hospital. The County Hospital is still the most sought-for hospital in our county. Statistics show that 82 per cent of the people who want to go to a hospital go to our County Hospital because they get the service for nothing. We made a study for about a year trying to get somewhere. We got statistics and we showed them to our medical society, and there never had been a time in the history of that society when so close to 100 per cent of all of our medical profession were behind that investigation, as long as those seven members of the county society committee were carrying the responsibility and the reputation for putting it over. There came a time when we felt that we should withdraw all support from our County Hospital, and we got up a resolution, which we signed, saying that we would stand as one to withdraw. Now, believe it or not, some five doctors, with the support of the supervisors and the people behind them, absolutely blocked that. The following year, at the election of officers, we put a young man in as president of the society, and I am honest when I tell you today that I do not know what happened; but the committee was discharged, a new committee was appointed, which was highly in sympathy with the County Hospital, the whole thing died and nothing more was said except by the medical superintendent of our County Hospital, who declared that he had killed the whole thing and that they did not dare even open their mouths any more.

One of the speakers yesterday said that he did not know where the idea was coming from that there was a request for this kind of insurance on the part of the doctors. I cannot understand where he has been all of this time. Perhaps he has been practicing in the city. Perhaps he has been away. Our report, a copy of which is here submitted, says that at least 30 per cent of our population is agricultural. I think that in San Joaquin County, Kern County, and those other counties in that great agricultural valley, the proportion of farm people must be very much greater, because we certainly feel the pressure, we feel the demand, and it is not a demand for an insurance plan. It is a demand for an open County Hospital, with free service; let the physicians find out how they are going to get paid! . . . Without going into any more great details, it seems to me that the crux of the whole situation resolves itself in a statement which I have written out here for myself: That the most important action necessary for this House of Delegates is to empower a representative committee to systematically coöperate with the Interim Committee, which is bound to propose some legislation which will not be in the nature of a voluntary insurance plan controlled by the organized medical profession. I do not feel that the resolution which is before the House is going to solve our situation. I do not believe that if we adopt that resolution it is going to take us to Sacramento to coöperate with the Interim Committee. I firmly believe that the thing that we must do is to coöperate with those people down there and help to back any law that they do pass, or we will have to take the bone that is thrown to us.

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Remarks by L. A. Packard, M.D.
Bakersfield

Mr. Speaker and Members of the House of Delegates:

I have heard a lot about Kern County while I have been sitting here, and I am very sorry to say that I have to admit it is all true, and probably more. Some of the things in connection with the situation in Kern County are very pertinent when it comes to the matter of health insurance. Someone mentioned yesterday that because we have a situation in Kern County which is as bad as it is or worse, that is no reason why the rest of the State should be driven into any hurried action; which is very true. However, the elements, the factors, which are connected with the Kern County situation have become so state-wide and lead out into so many branches that the Kern County situation is no longer a local situation. Two years ago, when the legislature convened there was organized in Kern County what was then called the Kern General Hospital Protective League. This was a political organization, designed to protect and further the interests of those individuals who were promoting the open county hospital. This hospital league has prospered greatly and received political favors. One year ago they went out into the State of California and organized a California County Hospital Protective League, and I assure you that the membership of this California County Hospital Protective League is powerful politically. You may have wondered, after hearing Doctor Yoell read the editorial which he offered you from the ***Farm Bureau Magazine,*** how a doctor in Kern County can make a living. It has been extremely difficult, and there is only one reason why many of the medical profession are still alive in Kern County, and that reason is insurance. Compensation insurance or health insurance. Kern County is very largely an in-

dustrial center. The oil industry employs many thousands of men. There is a wealth of compensation work in that field. In addition to the compensation work, we find there are numerous health organizations connected with corporations which are large employers of labor. I have no doubt that the proponents of the voluntary type of insurance will tell you that these are types of voluntary insurance, but we do not look upon them as such. They have so many mandatory features that these same mandatory features remove them from the voluntary field. There is no answer to a county hospital situation with voluntary insurance. If you went into our county with a voluntary medical and hospital program which cost the individual $15 per year, and you attached a $20 bill to each and every receipt, you could not sell it for $15. The Kern County Medical Society has been in the throes of this situation for almost five years. They have made a more or less detailed study of this situation and the remedies, and last Thursday night the Kern County Society met and passed a resolution which the delegate was instructed to read and present to this House, showing the feeling of one society which has had experience with this situation. This resolution was passed unanimously. I am not going to bore you by reading the entire resolution. I shall read only the last paragraph:

"The Kern County Medical Society places itself on record as favoring compulsory health insurance, and urges the California Medical Association to lend its efforts, to the end that such legislation be as favorable as possible and that the California Medical Association shall not enter into any insurance business or involve any of its members in any insurance business of any kind or nature."

* * *

Remarks by Rodney A. Yoell, M.D.
San Francisco

SPEECH NO. 2

Mr. Chairman and Members of the House of Delegates:

I arise to speak to you men today equally with the spirit of humility expressed by Doctor Kilgore. But this sense of humility that I feel, in discussing this problem, is the humility that one should feel in the presence of some great manifestation of nature's power. Humility does not necessarily mean a fear. Humility may very well mean a full understanding of the subject under contemplation, and I think that when we have finished our deliberations today medicine will feel a sense of humility, but medicine will have a sense of understanding.

I arise to speak in the justification of a right and the vindication of a principle. I arise to speak in the justification of the right of people, whom we all admit have not the individual capacity to finance health protection, to do so collectively. I arise to justify their right to a coöperative purchase of that protection. And with equal vehemence, I also arise to the right, and will fight for the right of the private competitive effort in the practice of medicine, the right to partake and join in an independent profession. . . . There is no man who has stood on this floor today who had the temerity to advocate the policy of do nothing. In this resolution that we are discussing we find a very characteristic thing, stale in its oldness. We have the same old harlot of voluntary insurance, with all her cheap finery, with all her false allurements, walking down the dream streets of expectancy under an illusion of chastity, and what is that illusion of chastity?

The illusion of chastity is that she feels she can pass herself off on other people as something that she has not any claim to, namely, virtue. Voluntary insurance, in the universal experience of mankind, has always exemplified the principle of prostitution. And why do I use the word "prostitution"? It is the correct word here. Yes, prostitution in the true sense of the word. Because the people who serve do not get their deserts, the people who pay are exploited, and usually the whole thing is a true perversion of principles, because under any system of voluntary insurance the thrifty stay in, the laggards do not come in. Those who are sick come in and when treated move out, and the stable members must pay. With such a plan you always are operating under a principle of adverse selection, which is false, misapplied, prostituted economics.

Voluntary insurance in this State is not a new thing. In the city by the Golden Gate we have two institutions which for over seventy years have operated so-called voluntary insurance plans. . . .

We have heard the question raised here that we should not indulge in theoretical debate. All right, let us agree. We are confronted here with facts, gentlemen, not theories, and I am going to show the facts. It is from these facts, and these facts only, that reasons can be adduced leading to the conclusions that we must accept the principle of compulsory health insurance as an answer to the problem, instead of voluntary insurance.

I am not arguing for a specific bill. Under the mandates of your House of Delegates, I had the honor to work on the Committee of Five, and to these men I pay my full need of respect. I have had drawn up a bill. That bill is not my bill, nor is it my plan. I have taken that bill from one end of the State to the other, submitting it to doctors, my own fellow practitioners, men like Catton, Ingber, Brooks, Porter, and others; and I have submitted it to a half-dozen other physicians; men in the city, men in the country, men in the small towns; from lawyers' offices, into the insurance companies, into industry and the railroads, in through the industries, in the fisheries, into the steel companies, up to the largest mining centers and back again, so that that bill represents the coördinated opinion of the best minds that we could get on the subject; but I will not argue for that bill. That is your question of privilege. I am merely arguing on the principle of mandatory insurance, because only under a system of mandatory insurance, developed under the right to the coöperative purchase of health protection, only under that system can we be free; otherwise State medicine is the inevitable alternative confronting us.

Now we hear a great deal from our adversaries, who charge us with excess of theory. Let me ask you this: Is this theory? Could the physicians of Kern County operate a voluntary insurance plan in Kern County under the present set-up? Is Doctor Packard here? I pause for a reply. Could you men of Kern County through your medical society, or otherwise, operate a voluntary insurance set-up in competition with the County Hospital?

Doctor Packard: Absolutely not.

Doctor Yoell: Now, remember that answer is a fact and not a theoretical argument.

Let us ask the men from San Joaquin County. Could they operate a voluntary insurance plan with any chance of success against the direct mandate of the people in the charter election authorizing the opening up to all non-indigents the use of the County Hospital? Doctor Powell, I pause for a reply.

Doctor Powell: I already answered, emphatically, no.

Doctor Yoell: Let me ask the man from Butte County, if he be here. A charter amendment is being submitted there in which it provides, according to Professor May of the University of California, that it be mandatory on the supervisors to hospitalize and give medical facilities and medical services to any citizen of the county, and transport him anywhere. Could you operate a system of voluntary insurance against a system of that kind?

Doctor Enloe: That is not passed yet. I do not know.

Doctor Yoell: Now, bearing those answers in mind, let us examine our opponent's theory against the facts. We hear a great deal about regimentation. That is a glorious word. It is like the old word "propaganda," an epithet according to who uses it; but it is a word that has been overused. Let us take the statement of these people who bring in comparisons between that which we want to do here and that which is being done in Europe. We are talking about insurance, and we are talking about the application of one of the greatest principles that belongs to any civilized coun-

try. Insurance is nothing new, but it is a civilized community's answer to a problem. Now, let me ask these men who oppose the idea of a mandatory system principle, and who accept the voluntary. Is there anything in Europe that separates their types of marine insurance from the type of marine insurance covering American ships? Is there anything in their personal liability insurance in Europe that differentiates that type of insurance from the type of liability insurance that exists in this country? No. Then, what is there in the peculiar nature of the application of the insurance principle against the hazard of illness that will work in Europe and will not work here? This is another challenging fact and not a theory, and I want facts and not theories in answer.

They talk about rugged individualism, they talk about stability of economic systems. They do not want the exercise of political power. How in God's world can we prevent it? If we do not pass the principle of mandatory insurance, and if it is passed by the people and we ignore the efforts that are being made, how much control can we expect from the county supervisors? Will medicine be able to instruct the board there? What sort of an arrangement would be made for our managing this thing? You men who have gone up against the supervisors in the various counties, as I have gone up, have you ever met with a coöperative spirit in the sense that they were willing to decide the mandate of the electorate, and refer it to what medicine knows is right and act on medicine's answer? Have you ever gone up before a lay group where the issue was what medicine considered right, and political or economic expediency dictated otherwise, and had medicine prevail? There is a fact and not a theory, and I want facts and not theories in your answer.

Now, what is there in this vaunted individuality? The individuality to suffer; the individuality to want; the individuality to feel sick; the individuality to die. There are 440,000 persons on relief in this very community today. Individuals! Individuals for what? To hold in their heart a want, an agony, and then to say that it is the duty of medicine to withhold from these people the one mechanism that the entire civilized experience of mankind has shown would remedy the situation. Is that the glory of our art? Is that the principle of our calling? Will this be our answer to the people of this great State? It was said yesterday that the great Morris Fishbein, the Eddie Cantor of medical economics, had expressed the opinion, that if anything should happen that was crack-brained and crazy, it would come out of California. Now, there was an insult. There was a fine comment on a people earnestly seeking the solution of a crying economic infamy.

Let us see the experience of one state society where they went to the fountainhead of wisdom, knowledge and fair dealing, as represented by the American Medical Association bureaucracy. I submit for your consideration a report from the Michigan State Medical Society that bears at its end the signature of its then secretary, Frederick Warnshuis, who is on our platform today. And I will recall to your minds that the progressive physicians of the great State of Michigan, cognizant of the economic problems and the economic drift of the times, went in humble obeisance and with a great spirit of humility to the temple of knowledge, to the gods on Parnassus in Chicago. Now, let us see how these men were received by these self-immortalized deities who hold unto themselves the fountainhead and source of imperial knowledge. They went and asked for certain information, and the report of their secretary back to the Michigan delegates was: [Reads from the Michigan report.] "To me the result of this meeting with our employees was both unsatisfactory and disturbing. Those present, in addition to the sick committee, were Dr. Bruce, Dr. West, Dr. Leland, Dr. Woodward and Dr. Carey, the ex-president of the American Medical Association. The Michigan delegates presented their problems before these men and asked for specific information. The information requested was not forthcoming, and the general attitude seemed antagonistic. While Doctor West kindly explained the workings of the American Medical Association, the discourse was not on the subject and failed to answer our questions. Doctor Leland appeared to be guarding 107 pages of manuscript on the subject of health insurance, but stated that he was not in a position to report. Doctor Carey magnanimously offered advice that seemed to be a bit gratuitous. He said that we should thoroughly thresh out the whole subject, that we should not involve ourselves, and that Michigan should delay lest it get into trouble. In short, the advice was, do nothing. Of course, all of this gave little information and less comfort to the Michigan Executive Committee that was present."

Now, here is a worse indictment. You can excuse people for doing nothing, but if people are informed and they have been officially requested to give information, and that information that is given out can be proven to be false, I care not whether it is in the American Medical Association, or otherwise, that is vicious and false, and deserves the utmost condemnation; and if we can get from this day's business a challenge to those men, that if we in California develop something that is not crazy and cracked-brained, but in the spirit of the pioneers that made this State, then I say, do it; but we will be honest, and it will not be built on the bottom of lies that have been emanating from Chicago sources of information. Article after article appearing week after week in the *Journal of the American Medical Association* was supposed to be by a British practitioner of medicine, a London leader; and when checked up (by these men who had to go to England to get their information, and not in their own organizations), when they got to England they found out that the preparation of the weekly letter had been placed in the hands of one who was not in general practice. Neither was he a member of the British Medical Association, or was there any record found of his having been at any time in the past thirty-three years. Then they took a publication in the *Journal of the American Medical Association* of a letter from a very distinguished Englishman, Sir Henry Brackenberry, an international authority on the subject of health insurance, and when they showed him this presumed copy of his letter this man made the statement that there was fraud, chicanery, deletion and distortion in the publication of his letter; that the salient points were left out, that interpolations were put in, and the whole purpose of the letter was so framed and so changed that it constituted an absolutely unwarranted attack on his true views. In other words, it was like taking the Bible and saying, "He went and fell amongst thieves; go thou and do likewise." I shall not bore you with the explanation that Sir Henry Brackenberry offered. I will say that the interpolated comments in the bulletin reports are unfair and misleading. This was an unworthy, detestably cheap type of attack.

Finally, after this very interesting experience, which was so graphically described for us over the signature of the member formerly of Michigan but present today, what was the resolution carried back officially to the Michigan directors: "Resolved, that in order to avert a repetition in the United States of the disturbing consequences that attended the adoption of health insurance in England, the House of Delegates shall appoint a committee to investigate and consider the policy of the Association toward health insurance, and present a report to the House of Delegates." In order to avert a repetition in the United States of the disturbing consequences attending the adoption of health insurance in England. In other words, medical men in England fought the law. They fought the inevitable in the tide of an economic storm in which they were caught. This thing moved with the impulse of an avalanche, and they failed to heed the warning; and the result is, that after twenty-five years, medicine stands today in England where we stand at the beginning of action if we but exercise our senses properly. Now, a stand that has to be taken in this country—and this is a fact—that we are apt to be met with successful legislative action by persons who neither know nor care for our problems. Here is the official journal

of the agricultural associations, the Pacific rural press, *The California Farmer,* and I merely quote because I do not wish to bore you; but this is factual, this is not theoretical; an editorial commenting on the health service, at an amazing low cost, furnished to Kern County. [Reads from paper.] "Here is the amazing story of what has eventuated. Ninety per cent of all hospital cases of the county now go to the County Hospital. A citizen may go to the hospital for medical treatment, for an operation, and even for dental treatment. The County Hospital also conducts the school nursing of the county. Thus, a complete health service is offered to the citizens. The cost is the amazing part. As a taxpayer, you help pay the costs of running the hospital, which amounts to an average of only $3 per capita per year. Almost unbelievable, is it not? If you, as an individual citizen, go to the hospital, you will find an even more amazing cost to yourself; but if you can pay, the total charge to you is only $3 per day as long as you are there. And so rural folks and city folks of Kern County, a large percentage of them, get their health service at cost, which is almost unbelievably low; and unless the upper courts sustain the Medical Association, this will endure."

Now, I submit this publication in evidence. [Hands copy to secretary.] I submit the report of the Canadian Medical Association, which endorses the principle of compulsory health insurance. [Hands copy to secretary.] I submit the report of the British Columbia Commission, which endorses compulsory health insurance. [Hands copy to secretary.] I submit the report of the British Medical Association, asking for a further extension and endorsing the principle of health insurance. [Hands copy to secretary.] And to show you that the legislative mind recognizes the inevitable trend in this country, I submit that four, and possibly five, counties in this State are proposing charter amendments opening up county hospitals to anyone. They are being written in the legal department of the University of California and in the department of political science. I point out also, in this connection, a letter from Senator Tickle, a distinguished member of the Interim Committee, and a sincere friend of medicine, which reads:

"Thanks for your very fine letter of June 8th, and the set-up you have outlined certainly coincides with my thoughts precisely. In view of the President's message to Congress, I am sure you fully appreciate the necessity of presenting a definite plan of health insurance at the next session of the legislature, for, failing this, I am rather fearful that the national government will tie health insurance on the tail of the kite of unemployment insurance, which I know you agree is something we do not wish.

"In fact, a study of the President's message rather convinces me that California should lead the way with a sound policy, and thus become the criterion of the nation. We can then turn our attention to unemployment insurance as something separate and apart from the cost of sickness. I feel you will also agree with me that in this way we can protect the medical fraternity and place them in their rightful position, and preserve them full integrity unto themselves.

"On account of pressing matters that needed my attention in this district, I had to hurry back from San Francisco last week, and regret I did not have sufficient time to see you. I shall do so, however, at the earliest possible moment, and in the meantime my every good wish is yours. "Sincerely,

"Edward H. Tickle."

This shows our legislators are informed and possess a keen understanding of our position in the picture.

And on May 29, after your Committee of Five was appointed, came another letter from Senator Tickle:

"My congratulations upon your selection to committee. I am sure you will contribute generously to the sum total of intelligence expended upon this concrete problem. Personally, I was hoping that the group would be authorized to present a plan instead of a survey and findings. Thank Heaven, you are familiar with the tomes of literature available on this subject. I trust your committee will hold a meeting at Del Monte, where I may join you in the near future.

"With every good wish, I am sincerely yours,

"Edward H. Tickle."

Let me call to your attention that there has been brought out at this convention, by several speakers of the opposition, particularly Doctor Wilson, the statement that probably we can defeat a proposed federal compulsory health insurance bill, should one be offered—which they doubt. They suggest they can merge or change such a bill into some voluntary plan, claiming that because certain bankers, manufacturers and industrialist groups are in opposition to the administration's social security plans, we can well join with them in opposition.

In other words, if there is a chance of defeating the administration, in conjunction with certain anti-Roosevelt opportunists, we might be successful in putting over a plan of voluntary insurance. This is futilely fatuous. The only majority defeat the Administration has so far received in the national Congress was with the labor bill. Wagner is the spokesman for the labor group. Labor demands his bill, and Wagner gives it to them. Can we face opposition like that and expect to beat it with childish plans of medically operated piddling voluntary insurance schemes? Is that a theory or is that a fact?

Is it a theory or is it a fact that your Committee of Five was asked to draw a plan and present a bill which might be available for the 1935 session of the California Legislature? I ask, what is the plan? Is it this so-called voluntary plan, badly conceived and hastily drawn, offered by Doctor Kilgore? This voluntary plan, specifically? [Holds out copy of proposal for voluntary insurance sent to members of the House of Delegates.] Then what of the bill ordered to go with it? Do we find any such? No!

Is it a bill that he thought we might get through the legislature certain types of insurance laws which would permit us to function as he suggests? Could we get this legislation through now, even if we would? Is this a fact or a theory? The same general type of plan was proposed in substance several years ago, and our counsel, Mr. Hartley Peart, rejected it at that time as being illegal in conception and incapable of legal consummation. And in order to fix it so it could function he had to draw up a bastard plan that would admit that corporations could practice medicine; and in order for it to exist legally it should include 55 per cent of the chiropractors, naturopaths, osteopaths, and all the rest of the licentiates that practice any branch of the so-called healing art.

Leading where? I say it is leading nowhere! It is a false phantasy to think that we can go ahead and plan to block a tide as irresistible as the rise and fall of the tides of the sea. Is this a fact or is this a theory?

Now, we hear a great deal about political control under a voluntary plan. I submit this: Other speakers will show the futility of the voluntary plan, but I again submit this, that regulated political control, with a fixed position of medical representation in the law, is an infinitely better situation for the profession than open conscienceless commercial competition in a chaotic field without regulation. While it is perfectly true we might be free from the regularly constituted politician, would we be free from the equally constituted medical politician, the chiseler within our ranks who, like the deserter hanging around the flank of a retreating army, is ready to cut the throats of the wounded for gain? Do they guarantee under the voluntary plan that, with an open panel, they can operate against a system working with a closed panel? This has been borne out acutely today before this organization in this very city. This local society has considered at great length the possibility of trying to operate a voluntary plan to protect itself against a certain going organization operating now in this great city. They have been in the offices of attorneys seeking counsel, and what has been the answer? Legally, you have no redress. You can do nothing along these lines. Now, then, up to yesterday noon no legal plan was presented with a single shred or iota of good legal opinion behind it supporting the vague plans of voluntary insurance presented by Doctor Wilson's group, because they have drawn no bill capable of forming a basis for any such sound legal opinion favorable to this plan. The only opinion expressed against the constitutionality of a compulsory act passed by the legislature is that possibly it would be safer and more desirable that the constitution should be amended and thus prevent constant legislative amendations and changes. By having an initiative, or by a constitutional amendment, a compulsory act would be safer. I have file

after file from competent attorneys, some of the ablest legal minds in this State, who have fully briefed for four months this question, and it is the opinion of several men that the legislature can pass such an act. It is the opinion of some other of these men that this act should be supported by a constitutional amendment, but it is not necessary to have the constitutional amendment before the legislature acts; and if the legislature acts, and acts adversely by passing some bill unjust to us, then we have to test the constitutionality of it in a court, with a public mind against us and years of litigation before we could be free. Now, there is a fact, and not a theory.

In summary, I hold no brief for any particular plan, but I do fight for justification of the right of the public to collectively purchase health protection and the vindication of the right of competitive effort in medical practice. And I say further, and most emphatically, that if we doctors have a legally constituted position in the law, if we can have a group of men selected by the board of regents of the University of California, and the foresight to realize that there would be sane, decent laymen on the governing board or authority, and that licensed medical men could also act on it—but not *per se* as representatives of the California Medical Association—I say with such a set-up, medicine in California should be able to secure two men: licensed men, drawn from its own ranks, who, impressed with our own ideals and a loyalty to the public and their profession, could occupy such positions with the utmost fairness. I say the challenge of Doctor Kilgore is incorrect, that under such a plan the dishonest doctor, the chiseling physician, the malingerer, and the cheat would ultimately succeed. That is not my opinion of my profession. Medicine can and will serve, and can and will serve justly.

Now what is the proposition they present? The opposition asks us to underwrite the risk of the care of the people of California—that we be morally responsible; scientifically responsible, legally responsible, financially responsible. They ask too much. They ask that the sacrificial christ of medicine be laid upon the cross of conscienceless commercial competition, and that the ever-attendant rabble be permitted to gather about the foot of that cross, and divide up his garments.

They shall not take this State, this State and these people that we love so well—this State from out whose soil some of us spring, and upon the bounty of whose soil others have come to live and whom we all regard and love almost as one regards and loves a mother; they shall not say to our people we, and we alone, stand in opposition to the one thing so sorely needed by 77 per cent of these people.

Shall it be the attitude of organized medicine (which will be published throughout the length and breadth of the land) that after eight months of study, after the expenditure of over $86,000, and after the full coöperation and recommendations of the best intelligences drawn from the great universities of this State, that medicine shirks her honor and refuses to do the sane, the essential, the decent, the kindly, the civilized thing.

Oh, ye men of medicine, if I could but give to you the clarity of vision to see this thing as some of us see it! God forbid that we who see it thus should fail, unconvincing in our trial. If you who in the darkest watches of the night hear the first feeble cry of the newborn child, if you who watch all too often the tremulous closing of the eyelids of the dying, if you who see all these things in their full significance could equally see the issue as it lies within the future, forecast—what should our answer be, negation or acquiescence?

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Remarks by John C. Ruddock, M.D.
Los Angeles

Mr. Speaker and Members of the House of Delegates:

I am proud to be a doctor. I am proud of the things that the word "doctor" stands for, and has stood for the past one hundred years. I am proud, also, of the American Medical Association, in spite of some of the remarks of previous speakers, because that Association stood up and announced itself as definitely opposed to those things tending to undermine the practice of medicine for the past century. Because of a depression that has affected the economics of every phase of our social existence, we find ourselves in the predicament of attempting to solve an economic problem.

I do not believe that there is the crying need which social workers, the Rosenwald fund, the Twentieth Century Fund, and other organized social uplifters are seeking to make us believe. They give large figures which would make us think that one-half of the population is crying for medical attention, and are suffering because they are not obtaining it. I have seen no figures which tell us how many people have been sick and have been unable to get attention. We know that only 10 per cent of our population is ill at one time, unless there is an epidemic, and in such an extremity the medical profession always has, will now, and always will offer their services, and see that none are unprovided for.

I challenge Doctor Yoell to prove his statements that there is a crying need by the populace. He staggers us with figures and reports and excerpts from articles, but the average person does not know what it is all about.

And now we have met here to discuss whether we shall discard the staid and proved methods of practice of medicine, the individual relation of the patient to his doctor—certain ethical standards of practice for a hypothetical, unproved medical practice that has not been successful in its various forms already tried in several foreign countries.

I believe in the insurance principle, and such a principle can be applied to the practice of medicine without jeopardizing the ideals of which we are all proud. However, you must admit that you cannot sell service, or put service on a monetary basis. There is not one of you who gives the same service, or a service of equal value to a patient. There is not one of you who has the same personality, and that is part of the thing that you are offering for a paid premium. It would be a simple matter to let a man buy insurance where he will, and give him cash sick benefits, and let him pay his doctor, whoever he may be, in the same manner in which he does it now. Why should the doctor keep shouldering the burden of the poor in the community, when it is a community problem, and not the doctor's problem alone. He should be concerned only with medical service and good medical service.

The problems of food, shelter, and clothing are so intimately entwined in the problem of so-called medical economics that it is impossible to separate them.

This convention should be discussing ways and means to improve the standards of doctors, to protect the practice of medicine from the inroads of the cults, to stop the vicious fee splitting, the overcharging and the ambulance chasing, and to prevent other practices that bring disrepute upon our profession. Our voice, or our desire, will not change in any respect the economic readjustment that is now going on; but our voice, if raised in defense of staid and proven principles, will command the respect of all.

Let us not be led astray by a few persons, whom I believe are very sincere in what they think is right, and are attempting to be missionaries and convert the rest of us to their way of thinking, be it right or wrong.

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Remarks by Theodore C. Lawson, M.D.
Oakland

Mr. Speaker and Members of the House of Delegates:

I come before you with an apology; in fact, with an humble apology. After we have listened to the very excellent, logical, level-headed presentation of the whole situation of medical insurance, as I see it, by Doctor Kilgore, and after listening to the very excellent presentation of the opposite side, and have listened to the heights of rhetoric with which the preceding speaker has favored us, and which I admire a great deal, I am afraid it is going to be a very disappointing anticlimax for you to listen to the few words that I have to say. I wish to represent the young, budding doctor as

nearly as I can, because my memory of the hospital days are not so far past, and I have an appreciation for some of the problems that the young doctor has had to face in the past, and is facing at the present time. Osler has said that the three stages of medical practice can be divided into three practically equal parts; the first stage is, when one is earning and eating crusts of bread; the second stage when one can add a little butter and an occasional cake to it, and the third stage when one can enjoy a little bit of ale along with it. I am still in the stage of the crusts of bread. I have not been in practice ten years yet, and I feel that I represent an opinion of the majority of the younger men in the community of Alameda County. . . .

One of the speakers, Doctor Ruddock, yesterday brought up a point as to who is asking for a change in medical economics? What is the demand for a change? Is it possible for the young doctor to go out into practice with economic conditions as they are, granting that nothing is done? Just for the sake of argument, I say, *yes*. Very distinctly, yes, even in this time of depression; if he has a good medical knowledge, sincerity of purpose, a moral life and good salesmanship. Granting also that something may have to be done, just for the sake of argument, I feel that in spite of the 77 per cent of the people who, we are told in cold statistics, can not afford good medical treatment under present conditions, at the present time in our county we are taking care of every single person who wants good medical care, and doing it well. First, we are giving our time, for the charity patients in our county hospitals, and I, among others, am glad to give my share of time freely. Every medical man in Alameda County is giving a share of his time. Secondly, the entire Alameda County Association has gone on record to be willing to take their turn in caring for part-pay patients who are not charity cases and yet who cannot pay the usual fees. These fees are regulated by the social service, according to their ability to pay. The third group represents those who can come into our private offices and pay the usual fee, and they are well taken care of. Of course, I merely agree here for the sake of argument that this does not apply to the entire State, and as a gentleman from Sacramento very well said yesterday, each county probably can take care of its own problem, if we will do nothing and make no changes. Again, coming back to the question, Who is doing all of this talking? My patients are not talking so much about it. Probably I am a young, what my friends might say, a young mossback. If I am, I want to know where I got off on a tangent, because I am very sincere in by beliefs, and I am talking for the younger practitioners at the present time. I feel sincerely that a part of it is being brought up before the public time and time again by the laymen who have no business with it, except that it has become a racket. I won't say that this is my personal opinion, and state it in such bald terms, but I will state that these lay organizations that are continually hounding us on this subject are making more or less a racket of it, and we, the medical profession, are the goats and the victims of it. I want to say that the majority of patients that come into my office are quite satisfied with things as they are. For the last year in Alameda County we have had the proposition of a voluntary hospital insurance plan, and I will venture to say that the majority of my patients would enter into it, if it were properly explained to them. I will agree with you that that represents a certain class of people only in a certain economic status; but I feel, in view of what Doctor Kilgore has mentioned about the voluntary plan started in Seattle, in view of my personal associations, and in talking with patients (my own and others), that it will work to a very satisfactory degree, at least until we see where we are, and until we get our foundations built for this superstructure which we hope to build.

Now, as to the compulsory plan. Personally, I feel it does not make any difference if we write in the bill at the present time that the medical profession shall have entire control, or whether the State Legislature writes its own bill. I agree with Doctor Kilgore's statement that the medical profession will eventually have no more say about it than the profession has in the British system. Again, I shall not feel so bad if a compulsory system comes so far as we physicians are concerned. We shall still make a living. I shall feel sincerely sorry for the patient, because this is what is going to happen, as sure as God made little apples, maybe not in five years after the compulsory system has been put into effect, maybe not in ten years; but maybe after our boys are practicing medicine, the following picture will be duplicated in the United States: A doctor went over to England to see a friend of his, who was a panel doctor, and being a sociable gentleman, he took his American friend out for a three days' outing. On their return there were thirty-eight patients in the panel physicians' office, and this is what the English doctor did: "All those having a cough, stand up." A stereotyped cough prescription was given to all of those who stood. "Anybody having a headache or pain, stand up." A few more stood up. Another already prepared prescription was given to them. And in a few minutes, probably not an hour, he summarized the rest of the cases that didn't have a cough or pain or headache, and he was through. I feel sorry for the patients. This will be an entering wedge toward State Medicine. That is all that is necessary. More and more regulations will be given, and more and more amendments will be put on. It will be a bill which will make it harder for the medical profession as we go along. The very fact that you gentlemen are in the United States today shows that your forefathers at some time, if they didn't come to the United States before the Declaration of Independence, came at least at a subsequent time, because they did not care for any regimentation or being told what to do as individuals within certain limits, as they were forced to do in old Europe. I personally resent, as an American citizen, as I am sure you all do, in being told by laymen how we shall conduct our own affairs, and how we shall manage our own matters of medical practice. . . . I feel that any bill for medical insurance right now, at the present time, that is drawn up will not fit the conditions five or ten years hence.

Now, we are told with a great deal of gloom, with a great deal of pessimism, that if we do not do something here today, tomorrow the State Legislature will snap a bill on us before we realize what has happened. Just to clarify the situation, Mr. Chairman, in the minds of a good many delegates here, I would like to ask some member of the Council—probably Dr. Junius Harris could tell us better than anybody at the present time—if that is the case, why is that situation allowed to exist? To my mind the finest thing that could have happened to organized medicine in California was this last initiative fight that we had on chiro-naturopathic amendments No. 9 and No. 17. It showed to me the strength that we, as members of the California Medical Association, really have in this State if we go to work. Up there in Alameda County we sent out thousands of personal letters and post cards through the County Medical Association to our patients, and we should have sent out thousands more if everybody sent out as many letters as they could. Some of the men sent out four and five hundred of those letters. I am very proud to observe that I doubt if there is a county in this State where there is more coöperation, less bickering, and fewer factions than in our Alameda County Medical Association. All the members work together. And if medicine can do that, and we would coöperate individually in the counties, and in the State Medical Association, and put our shoulders to the wheel, I do not think that the legislature will do anything against our concerted wish. . . .

We point here to the fact that medical care is one of the necessities of life, as clothing, food and shelter. Does your man in the SERA go to the grocery store and buy groceries on credit? No. He pays for them. The Government takes care of that. Does he go and get his house or apartment rent free? No. Provision is made for that. Some of my colleagues say (this is not my personal view), why not the same thing about the medical care of the individual patient? If it is a necessity, why not put it under the same heading?

Why, again, is the medical profession the goat all the time of these lay propagandists that keep talking about this all the time until you are nauseated with it? These lay organizations have as much right in dictating to us as to how we should conduct our business as one of us would have in telling the chief engineer of the San Francisco-Oakland Bay Bridge how to erect his piers, or the Big Six Companies how to construct the Boulder Dam. My father taught me to be respectful of age and experience. Age and experience in the form of the majority report of our Committee of Five have voted in favor of a voluntary insurance plan and against the compulsory plan. Age and experience in the form of the report of Reference Committee No. 1, to which this subject was referred by our speaker, have voted for the adoption of the voluntary insurance plan and against the compulsory plan. Gentlemen, in behalf of the younger members of our noble profession, I desire to state that we wish to be thus guided by the age and experience as represented by these two committees that have discharged their duties so ably. . . . It is our business to be interested in these problems. We are interested. We feel that these are our problems. We are one of the most charitable of all the professions. We will take care of the poor. We will even take care of the improvident, but we ask that we be permitted to do it in our own, American way. Let us build solidly, erect first the foundation and raise the superstructure gradually, and then we will know what kind of roof to put over it.

* * *

Remarks by C. Max Anderson, M.D.
Hermosa Beach

Mr. Speaker and Members of the House of Delegates:

There are two social economic philosophies concerned here: one on the right, which is the American system, and another on the extreme left, which is represented especially in Europe. . . . I want to call to the attention of the delegates the fact that there is a possible other solution of the problem—a middle ground. I am going to name the possible solutions that I have in mind in the order of least importance; that is, in order of least satisfactory solution first. First, the voluntary plan of insurance as submitted by the Committee of Five. Second, the compulsory plan of insurance, as presented by that same committee. Third, masterful inaction. Fourth, the plan that I submitted in resolution, namely, limited mutual benefit insurance, the insurance payment being made in cash and not in service. The objections to the plans that have been produced by the Committee of Five have been well discussed. They have been brought out by both sides. . . .

Considering now the resolutions before the House, I see no way in which the objectionable interposition of a third party, between the patient and his doctor, can be overcome. This is a very serious objection. Most doctors and most patients do not want a third party, sitting in an office miles away, dictating as to how much, how little, or what kind of treatment is to be given in a given instance, as is now the practice in the industrial insurance field. Regimentation and subjugation of the doctor and the patient as well are inevitable in the schemes presented. Increased commercialization of medicine cannot be kept out of the picture. To my mind the suggestion of collective bargaining in the buying of professional service is exceedingly pernicious. It simply means that the lowest bidder would be the man that gets the business, and aggregations of capital would be coming to the individual doctor to get him to give the lowest bid possible, resulting in the cheapest service possible. Then we have the political objections. I think none here are so naïve as to believe they are not very real.

I must very seriously object to the voluntary plan as putting the medical profession in the insurance business. Why, if the big insurance companies fear to go into this type of insurance, and will not enter this field, should we of the medical profession, with our lack of experience, enter the field? . . . I ask you to accept real insurance on a real insurance basis through limited mutual benefit insurance.

THE LURE OF MEDICAL HISTORY*

THE LOS ANGELES MEDICAL ASSOCIATION LIBRARY†

By CHAUNCEY D. LEAKE, Ph.D.
San Francisco

ENVIOUS societies of your colleagues elsewhere join in congratulating you on the splendidly designed and equipped library you are opening tonight to facilitate the advance of your professional activities in these beautiful meeting rooms. It is a great honor for me to have been asked to be with you. It is due to the amazing communication and transportation systems at present at our convenience that I can be with you. Ten days ago a telegram from Doctor Belt roused me from the dull surroundings of a lounge-car in El Paso, Texas. How it reached me there, I cannot fathom. Today I lectured, as is my job, to some dentists in San Francisco at 8 a. m., then to some chemists in Berkeley at 11 a. m., and now now this evening, after a delightful dinner, I am about to talk with some bibliophiles in Los Angeles, some four hundred miles from where I was this afternoon. When your library was conceived scarcely a generation ago, this would have all been impossible.

AN EARLY LIBRARY EFFORT BY THE ASSOCIATION

In the minutes of the Los Angeles Medical Association meeting of December 19, 1890, an inquisitive searcher, such as Dr. John Shuman, may read:

"The library committee reported that they had secured two dozen chairs, in addition to those previously reported on; also a chair for the president, and a new desk, and a seal for the society's use. The committee also reported that they had written a circular letter to publishers of all of the known journals of medicine published in the United States, numbering something over two hundred, requesting them to send their respective journals (gratuitously) to the library of the Los Angeles County Medical Association. The present administration assured us that the library is soon to be constructed."

Now, after forty-four years, and through the help of your friends, through the magnanimity of the Barlow Medical Library Association, and through your own fine spirit and coöperative enthusiasm, you have your own library building to house your precious books, some gratuitously enough received no doubt, and some secured by downright purchase and sometimes sacrifice. Maybe some small ones just appeared on your shelves, begotten in that delightful bookish way so whimsically and cleverly described in his address of dedication in 1926 at the Allen Memorial Medical Library of Cleveland by that eminent obstetrician, Harvey Cushing, who has brought forth so many grand ideas.

*A Twenty-Five Years Ago column, made up of excerpts from the official journal of the California Medical Association of twenty-five years ago, is printed in each issue of CALIFORNIA AND WESTERN MEDICINE. The column is one of the regular features of the Miscellany Department, and its page number will be found on the front cover.

† An address at the formal opening of the library of the Los Angeles County Medical Association, November 27, 1934.

A PARADOX OF GROWTH WITH MATURITY

Anyway, your library has grown as your society has grown, and you have both probably endured the same sort of growing pains. The analogy between an individual and a medical society or medical library does not hold beyond this adolescent period, for your society and library are now mature, but paradoxically still growing and developing, as will happen as long as they continue to serve a useful and worthy purpose. It is an unfailing mark of maturity for a medical library when it reaches the dignity indicated by the stiff shirts here this evening. You may now permit the queen of your guardian angels to become your gadfly, to be sure that neither of you, your Association nor your library become in any way stiff behind the dignity of your present garments, or that you become senile, decrepit, atrophic, or sclerotic by any lack of ability on your part to live wholesomely, generously and cleanly, as all things medical should live. Lest either of you ever have a tendency, during the long, long life of useful and joyful activity your friends are all wishing for you, to become haughty, arrogant, smug, or ungenerous, let it be hoped that some one of these friends may do you the real kindness of gently and occasionally reminding you of your adolescence. To all of us this is a reminder frequently as embarrassing as a baby picture, but often helpful in promoting that tolerant humility and honest modesty so characteristic of good books as well as of good men.

You have, I know, forgiven my presumption in showing you the baby picture of this now stately and great library. I hope you will be just as forgiving if I further presume to show you the companion picture of your great and growing society. It was also unearthed from the minutes of your society in the late seventies, which show "such lethargy that a meeting was held at the home of the secretary and a resolution passed declaring the office of president vacant for non-attendance." The next year there was but one meeting of the society and no officers were elected, the answers at roll call being too few. But that was before Iowa migrated, before a commercial use displaced a gentler medicinal one for the black smelly slime oozing from Rancho La Brera and Signal Hill, and also before movie stars fell on the city of the Queen of the Angels.

BENEFACTORS WHO HELPED MAKE YOUR PRESENT LIBRARY POSSIBLE

This evening's exercises are really a testimonial to all those valiant ones who struggled so long and hard to make your present society and library what they now are: the late Doctors W. Hendryx and F. A. Seymour, who with others first had the vision of a library for you some fifty years ago; Dr. Milbank Johnson, who as a faculty member of the then College of Medicine of the University of Southern California, really started the book-giving which created your collection and who was your first real librarian; Dr. Walter Jarvis Barlow, your most helpful patron, who so generously gave a $30,000 building and volumes in 1907 which were administered for your benefit by the Barlow Medical Library Association, and whose modesty now in connection with the use of his name you must not forget when "ripening time" suggests renaming your library or reading room; the Los Angeles Medical Department of the University of California, which in the passing years gave more than $10,000; Dr. Harlan Shoemaker, whose efforts to create a headquarters building fund have been rewarded by these noble buildings; the late Dr. Theodore Lyster; your present enthusiastic committee, headed by the distinguished book lover and medical historian, the clinician, George Dock, Dr. Elmer Belt, and Dr. H. E. Schiffbauer, and then your tireless librarians, past and present, and especially Mrs. Mary Irish, who has moved you here. What responsibilities rest on you, who are following, to justify the trust reposed in you by these who go before you! and what joy will be yours as that trust is well administered! Now that you have so nobly executed what visions your leaders have had of what a medical library should be, you have the pleasant obligation of preserving appropriate remembrance of them. And where more fittingly than in your library?

THE MEDICAL HISTORY OF CALIFORNIA

The medical history of California has been delightfully sketched by Dr. George Lyman, Dr. Adelaide Brown, Miss Louise Ophüls, Dr. George H. Kress, and others, in the historical symposium in the May, 1925, issue of CALIFORNIA AND WESTERN MEDICINE, in the *History of the Medical Profession of Southern California*, a volume brought off the press by Dr. George H. Kress in 1910, in Dr. John Shuman's account of medicine in Southern California, which was published in 1930 in the *Medical Journal and Record*, and especially in the brilliantly written and beautifully printed *California's Medical Story* by Dr. Henry Harris. As the interested physician goes over this material, he finds much in it to excite his curiosity and to stimulate him to discover more about the remarkable individuals who first brought rational medicine to the last great frontier, and about the extraordinary situations in which they often found themselves. Thus, Dr. George Lyman enjoyed himself immensely and contributed to the interest of us all by his study of the character and adventures of John Marsh, who got a license to practice medicine in California by showing a Latin bachelor's diploma from Harvard to the authorities of Los Angeles. He also got started on a fine story in searching out the grave-stone of Dr. Felix P. Wierzbicki, the liberty- and truth-loving Pole, who wrote the first book to be printed in English in California—*California as It Is and as It May Be, or a Guide to the Gold Region*, San Francisco, 1849—a book which revealed, incidentally, more truth than poetry about the newly opened country.

What thrills there are yet to be discovered by that medical Californiac who will investigate the medical practices of the California aborigenes! What a story might be reconstructed from the experiences of the surgeons who accompanied the sixteenth and seventeenth century exploring ex-

peditions of the Spanish, English, and Russians, the tentacles of whose empires were creeping out to reach a hold for the domination of the Pacific! Who was Dr. James Wood, surgeon to Francis Drake on the great privateering voyage around the globe, who performed the first postmortem examination in California in 1578, and died himself four days later? What are the details of the life of Dr. Pedro Prat, who ministered to the first Spanish colonists in California (1769-1773) and of whom Doctor Lyman says, "The sword, the cross, and the scalpel proceeded hand in hand, and had it not been for the presence of Pedro Prat, it is probable that the projected province would have miscarried and never withstood the travail of its birth." What of the career of the Spanish Surgeon-General, Dr. Pablo Soler, who was called the "Beloved Physician" by the grateful colonists during his period from 1792 to 1800, or of Dr. Manuel Quixano, the last of the Spanish Surgeon-Generals (1807-1824), whose medical instruments and effects Doctor Lyman found still in Monterey? Why not investigate the lives and works of the surgeon-generals of California under the Mexican régime (1824-1847) when American influence, such as reflected in the names of Edward Turner Bale, Richard Somerset Den, and John Marsh, was beginning to be felt? And then what romance and excitement are to be found in collecting data on the wild American physicians who added so much to the color of the Gold Rush and Vigilante periods! We all recall Gibbons, Cooper, Lane, Toland, Logan, Cole, who struggled like Titans in the North to found rival schools still surviving, and Osborn, Widney, Cullen, Orme, Lindley, MacGowan, Moore, Ellis, and others, who could work together more amicably in the gentler South.

For the treasures of story locked in such names, Doctors Lyman, Kress, Eloesser, Dock, Shuman, and Harris, have found a key. It is an easy one to use, and now with this splendid repository for such wealth, some of you must use it and bring your spoils here where they may be gloated over. It is only necessary for some of you to be curious, and then to look about a little on the slender clues you have; and you will be amazed at what you can find.

CALIFORNIA CONTRIBUTORS TO MEDICAL ADVANCEMENT

It is remarkable how many great contributors to medicine have been ripened by California sunshine. One may think of Dr. James Blake (1814-1893), who first showed a relation between the chemical constitution of a drug and its physiological action on the body, who first proved that the best treatment for tuberculosis is rest in the open air, and who was as zealous a scientist as any Arrowsmith; Dr. F. F. Fehleisen (1854-1924), discoverer of the bacterial etiology of erysipelas, who seems to have fled to the tolerant haven of California after making the political indiscretion of suggesting that the recent Kaiser's father might have had a syphilitic laryngitis; Jacques Loeb (1859-1924), the great mechanistic physiologist, and his brilliant Australian pupil, T. Brailsford Robertson (1884-1932); the noted pathologist, William Ophüls (1871-1933); the native sons, George H. F. Nuttall, one of the founders of modern parasitology, Joseph Erlanger, physiologist, Arthur Hirschfelder, pharmacologist and cardiologist, Herbert Evans, anatomist, Walter Alvarez, clinician; the Nobel prize winners, Thomas Hunt Morgan and George Whipple; and he whose spirit would rejoice in this evening's festivities, LeRoy Crummer (1872-1934), one of the greatest of medical bibliophiles.

Dr. Charles Singer, the outstanding English authority on the history of medicine and science, who graced the faculty of the University of California for a brief two years, has indicated, in his preface to Doctor Harris' *California's Medical Story,* that unusual opportunities exist in our State for the study and recording of an extraordinary medical development. We must not neglect the fleeting and perishable records of the recent years, or indeed of the present. Newspaper clippings, magazine articles, reprints, manuscripts, proofs of papers, programs of meetings, pictures—all these readily forgotten items form often the priceless possessions of libraries in times to come.

In the exhibit room of your library it is easy to visualize the permanent display you will make of material relating to California medicine: a case devoted to aboriginal medical practices; another relating to the Spanish period, from 1760 to 1824; a third, containing items from the Mexican régime from 1824 to 1847; a fourth, showing the American Gold Rush influence, and then one expanding case for your treasures from the more recent years. Significantly, after its unpleasant experience with the plague at the beginning of this century, California has pioneered in public health protection not only for the State, but for the nation; as witness its work in influenza, plague, poliomyelitis, psittacosis, and amebiasis. The records of these efforts can nowhere be better kept than in your library, close to where much of this public spirit has arisen.

MEDICAL LITERATURE FROM ALL LANDS AND AUTHORS

But a medical library must have at heart also the preservation of copies of medical classics from all lands and authors. The current productiveness in medicine is chiefly recorded in periodicals. The medical library is sorely pressed these days with shrinking currency and mounting costs of medical journals, especially foreign ones. And what a plague the number has become! Your librarian can testify to what a miserable matter it is for the librarian to handle such a variety of physical format. Why cannot we agree and standardize our journal sizes and bibliographical notations? But individualism in periodicals and books, no less than in men, resists regimentation, even for the sake of greater convenience!

Of greater dignity, of course, are those substantial medical classics printed from the fifteenth to the nineteenth centuries, which have survived the wearing down of time through the solidity of their merit. These are hard to obtain; but such

a library as this must try to secure them. It is astonishing how rapidly they multiply, once a lusty pair have been given sanctuary and nesting space on your shelves. Try the experiment of placing a cuneiform medical tablet (if you can get one) alongside an autographed reprint of an article embodying some of Dr. George Dock's medical wisdom (also if you can get one) and I think you will be surprised to find how quickly the whole gorgeous cavalcade of medical history will hatch out between them. You are fortunate in having the Huntington Library close at hand, so that you may learn to use its unique resources now being explored medically by Dr. Sanford Larkey. You are also fortunate in having the advantage of such sound advice in the gathering of medical classics as can be given by Doctors Dock and Belt, and Mrs. Myrtle Ingraham. What joy you will have working with them in building up the historical collection you should have!

THE MOST STRIKING FEATURE OF BOOKS

The most striking feature of books to me is their impartial generosity. This is especially true of medical books, for the writers in that fraternity belong to what is essentially a generous profession. To anyone who looks into these books on your shelves will the information they contain be imparted, varying only in the looker's ability to comprehend. The majority of those worthy to be on your shelves will breathe a rich aroma of helpful knowledge, and sometimes a sharper tang of genuine inspiration. When brains are bred with books, the gestation of genius has begun. Let the generosity of your books give you the clue regarding their use.

In his dedicatory address for the Boston Medical Library, December 3, 1878, at a time when your society could not even elect officers for lack of attendance, Oliver Wendell Holmes pleaded for the widest hospitality for all kinds of books relating to medicine. However hospitable you may be to books, however well you may care for them, file them, and catalogue them, they will be useless in the true sense unless you do everything possible to encourage their use. You recall Harvey Cushing's injunction:

"Mead's library motto, *'Non sibi sed toti,'* might fittingly be adopted for the *ex libris* of our great medical libraries. For a library must make unselfish use of its possessions even at the risk of an occasional loss. An open shelf, like an open shop, encourages the real worker, who often chooses to browse for himself. A library unexercised, and which takes no chances in life, is susceptible to the deterioration and sclerosis certain to attend a poor circulation. To be sure, with some people there is no mine and thine in the matter of books; but one must take the chance and fill in the gaps when they occur, however painful, temporarily, the loss. It's far better than not to be used at all."

The State Medical Library, sponsored by the editor of CALIFORNIA AND WESTERN MEDICINE and with the support of the California Medical Association, was created in California some five years ago for the purpose of trying to improve the public health and medical facilities of California by making it possible for the rural practitioner, far removed from such a library as yours, to keep abreast of current medical advance through a circulating periodical system for the lending, for a few days each month, of specialty and foreign journals. The only cost so far to the individual physician has been postage. You are cordially invited to coöperate in this venture through the south of California by coördination with the State Medical Library, whereby you might secure periodicals for permanent deposit on your shelves, thus saving you some of the costs of subscribing to them, and whereby your monograph and reference material might be made available to those outlying physicians who may have need of it. Thus may your library follow the impartial generosity of your books. At any rate, may you always help it to do its part toward making the common health the common wealth.

IN CONCLUSION

May your great new library, then, always prosper! Surely it will, if but hospitality toward any book relating to medicine and generosity in its use may always remain your guiding principles of operation. Under such a spirit you cannot fail to nurture greatness; and to the library of the Los Angeles Medical Association, then, that greatness will be thankful.

University of California Medical School,

CLINICAL NOTES AND CASE REPORTS

RHINOSCLEROMA*

By E. M. BINGHAM, M.D.
Arlington
AND
O. I. CUTLER, M.D.
Loma Linda

RHINOSCLEROMA is a moderately prevalent disease in central Europe, especially in Poland. In England and North America very few cases have been seen, although a fairly large number have been recognized in Central America. Approximately forty foreign-born individuals have been discovered to have the disease in the United States. Canfield[1] has recently reported the fifth case to be found in a native-born American.

H. E. Alderson,[2] of the Stanford University department of dermatology, has found two patients with rhinoscleroma in California. One of these he reported in 1914, the other in 1932. Another infection of this type has recently come to our attention.

REPORT OF CASE

C. F., a Mexican male of twenty-three years, was admitted to the Riverside County Hospital June 27, 1934. He complained of nasal obstruction, attacks of vertigo, and frequent headaches. He had been observed and expectant treatment given him in the nose and throat clinic of the out-patient department since January, and was sent in at this time for biopsy. He had had previous treatment in the same clinic in 1931, at which time a diagnosis of hypertrophic rhinitis was made.

* From the Riverside County Hospital and the department of pathology, College of Medical Evangelists.

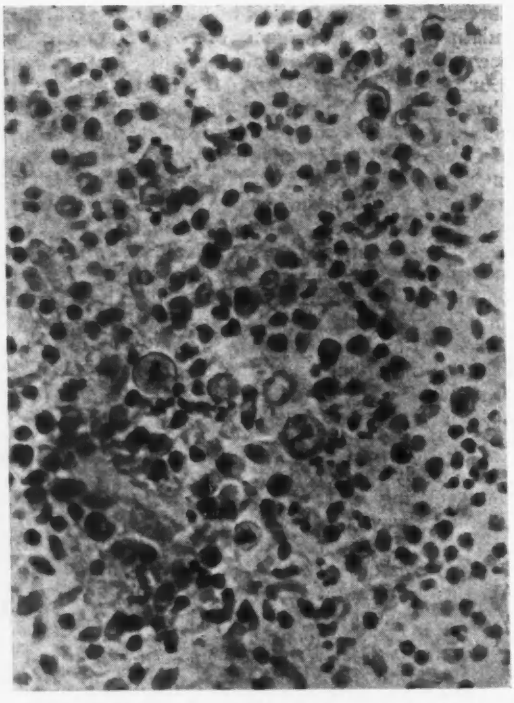

Fig. 1.—Rhinoscleroma. Microphotograph showing type of cellular reactions present. The two largest round objects are Mikulicz cells.

Past medical history was negative except for injury to nose when hit by a baseball in 1925. Apparently there was no fracture. He was born in Mexico and lived there until eight years old, residing in Riverside since that time. He had spent the months of August to December of the past four years in the Fresno district as a fruit picker. Two sisters, one brother, and parents were in good health.

General physical examination showed an apparently normal Mexican male. The nose showed hypertrophic changes of the turbinates, with obstruction of the nasal passages, more marked on the right. There were adhesions between the middle turbinates and the septum. The turbinates and adhesions were very firm and did not bleed readily.

Laboratory.—Normal urine; hemoglobin, 103 per cent; W. B. C., 7,400 with normal differential; blood Wassermann and Kahn, negative.

A small piece of tissue was removed from each side for microscopic section and the patient discharged June 29. When the pathological report was returned, he was called back to the hospital for further biopsies and cultures, being readmitted July 18. The following day there was moderate bleeding and he was not discharged until July 20.

The patient was seen in the out-patient department for approximately a month following surgery, when he again left for Fresno. He was given potassium iodid by mouth and sodium iodid (20 cubic centimeters, 10 per cent) intravenously three times a week. He did not tolerate iodids well, developing a very marked hoarseness. When last seen, he was subjectively improving and nasal obstruction had not recurred. He was instructed to continue taking the potassium iodid by mouth.

COMMENT

Rhinoscleroma is a chronic granuloma commonly involving the nose. The lesions frequently appear in other parts of the respiratory tract, including the larynx and trachea, and sometimes have spread to the skin. Because of the lack of confinement to the nose, it has been suggested that the name be simply "scleroma."

Besides the clinical findings, diagnosis is usually based on biopsy, although a complement fixation test has been used.

In the early stages of the disease the lesion presents only loose granulation tissue infiltrated with plasma cells and phagocytes. In such cases the diagnosis from sections alone may be difficult.[3]

After the disease is fully established, the recognition of it in the tissues is based on three criteria, all of which were found in tissue from our patient.

1. Large vacuolated phagocytic cells are present in the granulation tissue. Their nuclei are frequently pyknotic. These phagocytes are termed "Mikulicz cells."

2. A degeneration appears in the Mikulicz cells whereby hyalin material is formed.[4] The vacuoles in the Mikulicz cells enlarge and become eosinophilic. The nucleus becomes dark and compressed, and indented by the vacuoles about it. The vacuoles also produce bulges in the external outlines of the cells. Finally, the nucleus disappears, the cell-wall ruptures, and the spherical eosinophilic masses are seen in a loose clump in the tissue. They are commonly five to fifteen microns in diameter and are called "Unna bodies."

3. Gram-negative bacilli resembling Friedländer's pneumobacillus are found in the tissue. A large proportion of these are in the Mikulicz cells. The cultural characteristics of these organisms have been described by Figi and Thompson.[5]

In old lesions much dense and more or less hyalinized connective tissue is found. In this stage diagnosis by biopsy may be difficult, as Mikulicz cells and Unna bodies are often absent.

Except in the few instances in which more than one case has been found in a family, it has been very difficult to elicit any history of exposure to others who have the infection. The onset of the disease is insidious and prolonged. The disease is one which is usually found in the more illiterate classes.

SUMMARY

Three cases of rhinoscleroma have been found in California. The one which we are reporting appeared in a Mexican who has spent much of his life in Riverside.

Riverside County Hospital, Arlington.
College of Medical Evangelists, Loma Linda.

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BEDSIDE MEDICINE FOR BEDSIDE DOCTORS

An Open Forum for brief discussions of the workaday problems of the bedside doctor. Suggestions of subjects for discussions invited.

GENITAL AND ANAL PRURITUS

ETIOLOGY OF PRURITUS ANI

H. J. Templeton, M. D. (3115 Webster Street, Oakland).—Pruritus ani may be caused by etiologic agents as obvious and as near to the anal canal as simple fissures, or as complex and remote as some neurosis or psychic fixation in the central nervous system. The difficulty of discovering the etiology may vary from the ease of recognition of pinworms to the complexities of a complete medical study in some of the more obscure cases.

Local causes are the easiest to discover, and obviously the first to approach. When the skin around the anus is pearly gray and sodden, suspect epidermophytosis. This diagnosis may be strengthened by finding a concurrent epidermophytosis of the toes and can be clinched by finding the fungi in scrapings. An irritating leukorrhea may be the cause of the pruritus; or, likewise, a diabetic urine. Fissures and external hemorrhoids are obviously possible trouble makers. Sometimes local infection, with such streptococci as the S. fecalis or other pathogens, may be causative; but it is difficult to prove this. Cultures, intradermal tests and appropriate vaccine therapy would seem to be in order in obstinate cases. A well-taken history will often disclose that the patient is applying some substance which is acting as an external irritant. In this respect one should think of anusol or other hemorrhoidal suppositories, butesyn picrate and other ointments, particularly those containing resorcin. I am aware of at least one patient who is extremely sensitive to toilet paper, and, in general, I feel that the use of toilet paper should be prohibited temporarily, substituting damp cotton therefor. The seepage from mineral oil may produce anal irritation.

Intrarectal pathology may produce pruritus ani. Therefore, proctoscopic examinations and the help of a proctologist are advisable. Internal hemorrhoids, cryptitis, stricture, are representative of this group. Gastro-intestinal infections, such as amebiasis, colitis, and diarrheas, as well as infestation with the various intestinal worms, must be considered.

Noxious stimuli over afferent nerves from pelvic or abdominal pathology may be reflexly referred out over efferent fibers to the perineum, and be interpreted as a pruritus ani. Thus pregnancy, appendicitis, salpingitis and prostatitis may produce the pruritus. Illustrative of this point, but certainly a medical curiosity, is Maynard's case of pruritus ani, apparently caused by a huge umbilical calculus and cured by removal of it.

Certain dermatoses may localize around the anus and produce pruritus. This occurs fairly commonly in seborrheic dermatitis. Inspect the scalp, pubic area, and axillae. Eczema may localize around the anus as a part of eczema elsewhere on the body.

There are many systemic disorders which can produce itching of the anus. Possibly foremost among these stands diabetes. Other less common causes are icterus, leukemia, cardiovascular and renal breakdown. Allergy is responsible for some of these cases. I can recall one patient whose pruritus was cured by a milk-free diet. Or, as mentioned above, the pruritus ani may be due to a localized patch of a widespread allergic eczema.

Of the less tangible causes, one should mention the neuroses and psychic fixations. Stokes has emphasized this phase of the etiology. I have seen several such. One patient developed a pruritus vulvae et ani because of fear of intercourse with her husband, who had tuberculosis of the epididymus. A male patient of an age when his sexual powers normally were waning developed a pruritus ani as a defense reaction against his wife's Messalina-like demands. Such cases demand study by a neurologist.

* * *

DIAGNOSIS AND PROGNOSIS

H. P. Jacobson, M. D. (2007 Wilshire Boulevard, Los Angeles).—Diagnosis and prognosis of pruritus vulvae et ani depend upon discovery of the underlying causative mechanism, and upon the character of the etiologic agent in a given case. The sensation of pruritus, it will be recalled, may either be a local symptomatic expression of a disease process situated near to or distantly removed from the pruritic area, or the symptom-complex may constitute a disease entity *sui generis*, without any observable organic tissue changes *in situ* or in any other organ of the body to account for the trouble. For clinical diagnostic purposes, the disorder lends itself to study under the following classification:

1. Pruritus vulvae et ani due to local causes;

2. Pruritus vulvae et ani due to systemic or visceral diseases;

3. Essential pruritus vulvae et ani of unascertainable etiology.

1. *Pruritus Due to Local Causes.*—This form of the disorder may be encountered in both sexes at any age, though the anal form is observed most frequently in the adult male. Its inception may have its origin in irritating discharges from the bowel, rectum, or genito-urinary tract; in the local employment of antiseptic or contraceptive chemicals; in the mechanical or toxic action of protozoal organisms (Oxyuris vermicularis, pediculi, amebae, and trichomonas vaginalis); in bacterial infections (coli, streptococci, and gonococci); and

in fungal infections (yeast-like fungi, epidermophyta, and trichophyta).

The mechanism by which these different agents give rise to the annoying symptom of pruritus differs considerably. In cases of irritating discharges (regardless of whether these originate in cervical, vaginal, urinary, or anorectal-intestinal diseases, including hemorrhoids, anal fissures, etc.), the mechanism is probably that of a direct abrasive action upon the epidermal covering primarily, followed secondarily by an excitant effect upon the tactile sensory nerve organs of the involved parts, resulting in the sensation of pruritus.

In the parasitic form of the disorder, the mechanism concerned is largely determined by the character of the causative organisms. The oxyuria vermicularis, for instance, give rise to the sensation of itching or crawling by their very presence and locomotion across the mucocutaneous surface, thereby exciting (mechanically) the tactile sensory nerve organs of the parts. On the other hand, pruritus of bacterial or mycotic origin usually involves a mechanism more complicated, though benign, in character. The process here is essentially one of tissue defense, and consists, in addition to edema, of a mobilization of cellular elements in response to invading microörganisms, their toxins and metabolic products, and a direct excitant action of all these upon the sensory and tactile nerve organs of the parts, expressing themselves clinically in the sensation of pruritus.

2. *Pruritus Due to Systemic or Visceral Disease.*—Under this caption may be included those cases of pruritus vulvae et ani which may be traced to functional or organic tissue changes in some organ or viscus not directly connected with the pruritic area. Lack of space will not permit thorough consideration of this phase of the problem, but for purposes of illustration the following may be listed as frequent sources of origin:

(*a*) Foci of infection, no matter where located, but especially those situated in the urogenital organs, may reflexly or through direct toxic action excite the tactile sensory nerve organs of the anogenital tracts, and give rise to the sensation of itching.

(*b*) Portal congestion due to hepatic disease, or to local obstruction from tumors in the abdominal cavity, or from uterine pressure in the late stages of pregnancy, may reflexly, or through direct toxic action upon the tactile sensory nerve organs, give rise to pruritus.

(*c*) Intra-abdominal neoplasms, Hodgkin's disease, and the leukemias, possibly through a selective toxic action upon the tactile and sensory nerve organs, not infrequently give rise to anogenital pruritus.

(*d*) Intestinal stasis, nephritis, and especially diabetes, through toxic action of the respective metabolic products upon the tactile sensory nerve filaments of the anal and genital systems, not uncommonly express themselves clinically in the symptom of pruritus.

3. *Pruritus Ani et Vulvae Due to Undiscoverable Causes—Essential Pruritus.*—In this category belong the cases of so-called essential pruritus in which no causative mechanism is discoverable upon examination. It is probably a disease entity *sui generis,* and from the therapeutic and prognostic standpoints constitutes a most troublesome problem. The genital form is met with most frequently in the female sex during the climacterium, though it may be observed in both sexes at any period of adult life. The disorder is primarily a localized neurosis of the anal-genital tracts, usually without any observable organic mucocutaneous changes, except such as may be produced by the patient's scratching in an endeavor to obtain relief from itching.

Regardless of what group or category a given case of pruritus ani or vulvae may belong to, the essential and frequently only symptom for which medical relief is sought is pruritus. It is a most distressing sensation, and the victims will usually gladly submit to any form of painful therapy in order to be relieved of the agonizing itching, crawling, or pricking sensation. The itching may be persistent or paroxysmal in character, but is especially annoying after sunset, and particularly after retiring to a comfortable, warm bed. The desire to scratch constantly is so irresistibly agonizing that these patients not uncommonly are obliged to shun society and to become burdens to themselves and to their surrounding associates, friends, and families.

From what has been said, it is obvious that from the diagnostic standpoint the symptom of pruritus *per se* is of no more significance than is that of headache, backache, or any other similar complaint. Like headache or backache, it may be a clinical expression of any one of a number of disease entities, requiring diligent search and study for a correct diagnosis.

The examination of the patient should begin with the taking of a careful and pertinent history, in an endeavor to obtain a clue or clues which may enable the examiner to classify a particular case under the proper category. Such items as personal habits, diet, past illnesses, and the use of drugs (especially local antiseptics and contraceptives) should be gone into thoroughly, and the question of food sensitization should be accorded adequate consideration. This should be followed by a general inspection of the entire body, with a view of eliminating such humble offenders as Acarus scabiei and Pediculosis pubis as possible etiologic agents, and/or such other cutaneous conditions as may serve to throw light upon the existing pruritus.

The various systems and organs should receive such attention as the indications in a given case may require, and the laboratory procedures should be of such a character as to meet the indications in a given situation.

Dermatologic Earmarks. — From the dermatological standpoint, each type of pruritus vulvae et ani frequently presents some fairly characteristic objective features, susceptible, in a majority of instances, of correct interpretation by an experienced dermatological observer. Lack of space will only permit a general schematic outline of such suggestive features, and these may be submitted

(in accordance with classification previously outlined) as follows:

Group 1 (pruritus due to local causes). The common outstanding dermatological characteristics frequently separating this from the other two groups are : (*a*) sharp definition of the cutaneous eruption; (*b*) absence of infiltration; (*c*) mucocutaneous eruption preceding pruritus (excepting cases due to oxyuris vermicularis, and, occasionally, to contraceptive and antiseptic chemicals).

The cutaneous eruptions in pruritus cases due to bacterial infections (Streptococcus fecalis, Bacillus coli, or gonocci) are actually characterized by a good deal of inflammatory tissue reaction, frequently associated with vesiculation and oozing. Dermatitis produced by irritating discharges (from rectum or urogenital systems) is not uncommonly associated with a good deal of epidermal abrasion, and is subject to exacerbations and remissions, according to the amount and character of the discharge.

Pruritic dermatoses caused by members of the different genera of fungi (except in the presence of secondary bacterial infections) usually consist of sharply defined, noninfiltrated, only very slightly elevated, erythematous, scaly, dry patches, presenting little or no inflammatory reaction. Members of the monilia genus and some members of the trichophyton genus may, however, produce vesicular lesions, arranged discretely or coalescing to form sharply marginated patches. The vesicular lesions caused by these fungi are situated more deeply in the skin than are those produced by the bacteria and are, therefore, more tense and less subject to spontaneous rupture than are the vesicular elements caused by the latter organisms.

Group 2. In this, the so-called systemic type of pruritus vulvae et ani, the symptom of itching usually precedes the cutaneous eruption, though occasionally the reverse may be true. The eruption is commonly of the eczematous type, and consists of erythema, vesicles, and papules all combined in a given patch; or the latter may consist of any one or two of the three primary elements. Regardless, however, of the composition of a given patch, its outline is usually poorly defined, its surface may be moist and oozing or relatively dry, but infiltration sooner or later becomes a prominent feature.

Group 3. In this category belong the cases of so-called essential pruritus vulvae et ani. The disorder here is primarily and solely a pruritus without any observable organic mucocutaneous changes, and presenting no visible dermatological evidence of cutaneous disease. Such visible mucocutaneous pathology as may finally become manifest is usually secondary in character, a result of persistent mechanical insult inflicted by the patient (rubbing and scratching) in an endeavor to obtain relief from itching.

Prognosis.—Regarding the prognosis of pruritus vulvae et ani, little need be said in addition to what has been stated previously. The outcome of any case of pruritus depends upon the character of the etiological mechanism at work, and upon the ability of the attending physician to discover the cause and to employ proper therapeutic measures. Pruritus due to local causes lends itself to therapeutic management with a good deal of facility, and the prognosis is, accordingly, good in the majority of cases.

The prognosis of pruritus vulvae et ani secondary to systemic disease (second group) naturally depends upon the character of the underlying disorder responsible for the itching. In a general way it may be said that in the majority of cases (except those due to malignant neoplasms or organic spinal diseases) the prognosis is good, if the cause is discovered and removed or treated properly.

The prognosis of anal-genital pruritus of the third group—essential pruritus—is somewhat uncertain. By the older methods of treatment in vogue, the prognosis may be said to be essentially unfavorable in the majority of cases. The therapeutic results achieved are, at best, only temporary in character, and the pruritic parts, in a good many instances, following a series of relapses of itching in spite of treatment, sooner or later become infiltrated, leukoplakial, and, finally, epitheliomatous. With the presently available, newer methods of treatment by means of alcoholic and anesthetic injections, however, this aspect of the problem is assuming a different complexion, and a better prognosis is in the offing. Dr. Norman J. Kilbourne treated a good many cases of this form of pruritus vulvae et ani by means of injections, and is very enthusiastic over the therapeutic results he has been able to achieve. My own personal experience with this form of treatment is limited in character, but the results have been so favorable that I feel the method deserves wider clinical application with prospects of enhancing the prognosis in this form of the disorder immensely.

* * *

TREATMENT OF PRURITUS OF THE ANUS AND GENITALIA

HARRY E. ALDERSON, M. D. (Stanford University Medical School, San Francisco).—An occasional annoying symptom to some, a persistent, very distressing one with agonizing periods of acute exacerbation to others, pruritus of the anus or genitalia is a subject of wide interest calling for discussion in these columns from time to time. In this JOURNAL (January, 1927) was published an article by the author of this one, stressing the fact that this form of localized pruritus is largely a symptomatic condition due to causes acting "reflexly" and complicated by local conditions. My views regarding etiology have not changed, but I have some useful suggestions to present regarding treatment.

It goes without saying that one should not attempt to treat these cases without giving careful consideration to the patient's general condition. Failure to take into account the possibility of the existence of high-blood sugar, hypothyroidism, or hyperthyroidism, will explain some therapeutic disappointments. These conditions not only will produce increased vulnerability of the skin and

susceptibility to secondary infections, but such skins will lack the normal tendency to recover quickly from an injury. It is useful, too, to remember that occasionally pruritus ani will herald the onset of tabes dorsalis. In many cases indiscretions in diet, as well as food idiosyncrasies, will have to be attended to. Alcoholism, excessive use of tobacco, or drug addiction, when existent must be taken care of. Likewise when intestinal parasites are present they must be eliminated. I have known cases of anal pruritus where relief was not obtained until the patients stopped taking mineral oil. So a vitally important part of the treatment is found to be constitutional, and the gastro-intestinal tract should be the object of very careful consideration.

Pruritus of the anus and genitalia often exist together, and as the symptom frequently is produced "reflexly" by disturbances in some pelvic structure, the treatment is obvious. Local skin and mucous membrane changes, associated with the menopause or senility, produce some of our cases. Here endocrinotherapy may help, but one must rely mainly upon certain local measures, to be discussed presently. Quite often the removal of hemorrhoids, the eradication of rectal growths, fissures of ulcers, will relieve pruritus ani. The successful treatment of vaginal or uterine disease often will be followed by subsidence of pruritus vulvae.

If the patient has a seborrheal skin, the itching may be more severe, and eczema, and at times pyogenic infections, may result, greatly complicating the situation. Such cases may be much helped by cleansing drying lotions, roentgen therapy, and ultra-violet treatments, which will be discussed later.

One often hears of cases which are assumed to be due to the presence of a local mycotic infection. It is easy to demonstrate the presence of fungi and other organisms in scrapings from the anal and genital regions of most any individual. Even where there is obvious local inflammation from this cause, I believe that there usually are more important underlying etiologic factors, as already suggested. Naturally, one's treatment should include measures to combat local infections. I do not agree with those who claim that most cases are due entirely to local mycotic infections.

Many cases are complicated by overtreatment. Often the skin and mucosa are so damaged, and all one can do for a few days is to apply most soothing preparations until healing takes place. A weak cocain ointment or liquor alumini subacetatis compresses (containing Burrow's solution, diluted sixteen times) will be very useful here. This preliminary treatment is also very beneficial when there is edema and inflammation due to scratching. Tiny abrasions are very apt to be the starting points of widely spread itching. Applications to these abrasions of a five or ten per cent silver nitrate solution are indicated. When the results of excessive local stimulation are thus palliated, systematic curative therapy can be instituted.

If patients have to scratch (and they often do), they can be taught to press hard on the itching spot with the fingers covered with thick cotton cloth. Of course, it is better when this occurs to apply some of the salves or lotions to be discussed later; but it is not always convenient to do so. As the surface is usually moist the drying of the same by a clean cotton cloth, absorbent toilet paper, or the use of a carbon tetrachlorid lotion, usually gives relief which may last through the night.

Paroxysms of perianal itching often are started by the appearance of a very small amount of rectal secretion finding its way along the radiating lines and creases or tiny fissures that are present. This occurrence sometimes may be made less likely by the administration of a small cleansing rectal enema at bedtime. Locally, a "dry cleaner," like carbon tetrachlorid c. p. diluted one-tenth with albolene or lanolin and two-thirds with dilute alcohol, is very helpful. The preliminary smarting which results also has a good antipruritic effect. This lotion also may be applied on soft absorbent toilet paper after bowel movements.

The carbon tetrachlorid lotion (which I originated in 1923, *Archives of Dermatology and Syphilology,* 8:411-415, September, 1923) should be diluted, for some individuals become dizzy if they inhale much of it. This preparation, being a good solvent, removes secretions and excretions from the follicles, ducts and creases in the skin, and acts as a bactericidal and fungicidal agent. The addition of two per cent camphor will increase its antipruritic and drying effects. It will be helpful to cleanse the regions morning and night with this lotion. Should the skin become too dry, more oil may be added to the solution or one-half per cent phenol in vaselin may be applied.

I have practically abandoned the local use of powders in this condition, as they are difficult to apply. The hair and other factors make it impossible to properly powder the skin. Occasionally, however, the following may be useful:

℞ phenol 0.6
acid salicylic 2.0
zinc oxid 25.0
amyli q. s. ad. 60.0
M. in fine powder
Sig: Apply freely

A simple ointment, containing ten per cent of calomel, often is helpful. Also one or two per cent of phenol, with one per cent menthol in olive oil or simple ointment, will give relief. It must be remembered that phenol preparations may in time cause local necrosis.

Tars are often recommended. They will dry the area; they will also relieve itching. The fact that they have carcinogenic properties is, in my opinion, a very serious objection to their use here. This is particularly true of crude coal tar. I rarely use them around the anus, but at times have prescribed a weak liquor carbonis detergens ointment with satisfactory results. Even in these cases, however, I have felt that possibly a two per cent preparation of camphor in simple ointment, or a plain grease alone, would have done as much.

The application of adrenalin solution, several times daily on pads of gauze, by contracting the capillaries, may be very helpful. This is particularly true if there is eczema.

Roentgen therapy has a local sedative and a drying effect. It should be used most cautiously, bearing in mind the danger of producing radiodermatitis and also possible untoward effects on the testicles. We usually administer one-quarter of a skin unit filtered with one millimeter of aluminum weekly, and are careful not to exceed one full skin unit within a month. We have seen some advanced cases of radiodermatitis (and in one instance a superimposed carcinoma) resulting from overtreatment at the hands of others. One patient had gone the rounds of several radiologists, who had given him many treatments without knowing that the individual had had the same given by others. His intergluteal region was covered with a network of telangiectases, and keratoses were beginning to appear. Of course, the average radiologist would never give this treatment without being sure of the past history. Roentgen treatment will relieve for weeks at a time, but the condition will flare up again if the causes are not removed.

Ultra-violet exposures may be helpful by toughening and drying the skin. Its superficial bactericidal and fungicidal action also is beneficial.

Surgical removal of the skin involved, nerve resection, nerve injection, and other measures to produce complete local anesthesia will give relief. However, the results are apt to be only temporary, as nerve regeneration occurs.

To do full justice to our patients we should exert every effort to discover and eradicate the underlying causes, and not be satisfied with local therapy alone. The foregoing suggestions apply to the treatment of pruritus of the anus, as well as that of the genitalia.

A Medical Trade Union.—The Medical Practitioners' Union is a trade union, which was formed in 1915 by physicians who thought that an organization on these lines, which have never been adopted by the British Medical Association, was desirable. It is a smaller body and has nearly 6,000 members. It has joined forces with the other labor unions. The General Council of the Trades Union Congress has accepted the proposal of the Medical Practitioners' Union for affiliation. This is the first time that a medical society has been linked up with the Trades Union Congress. In a press interview the secretary of the union stated that the object of this move is mainly to protect members who are engaged by county and municipal authorities. "Where negotiations are needed," he said, "it will give added strength, but it must not be taken that this affiliation means the possibility of a strike against the sick. Every union affiliated with the Trades Union Congress is governed by its own rules and that, of course, applies to us. It is unthinkable that there should be a strike against people who are ill, nor would anybody expect doctors to take such a step. We are endeavoring to help many members of our union, and to do that we have had to apply wholly as a union." It is one of the objects of the trade unions to be able to declare a general strike, and one actually took place a few years ago but was unsuccessful. The government was equal to the emergency and essential services were maintained by volunteers. It is understood that the application from the Medical Practitioners' Union was accepted without qualification, no specific point being raised on the question of a general strike. The calling out of the physicians in the case of another general strike would be the reductio ad absurdum of trade unionism. The majority of the physicians in this country abhor this movement by a section of the profession. It is certainly due to the great increase of state interference in medical practice in recent years, of which the most important manifestation is health insurance of the wage earners. The idea is, as indicated, to confront the state or the local authorities who employ physicians by a powerful organization.

THE POSITION OF THE BRITISH MEDICAL ASSOCIATION

The question has arisen: Can these medical trade unionists retain membership in the British Medical Association, which is opposed to anything that savors of the political? In a press interview the secretary of the Medical Practitioners Union said that they were not concerned with politics but only with medical politics—a vastly different thing. Both organizations were voluntary bodies, and physicians could be members of both, just as they could be members of two golf clubs. He saw no reason why the two bodies should clash. However, Doctor Anderson, medical secretary of the British Medical Association, has expressed a different view in another press interview. He agreed that physicians may still subscribe to membership in both organizations but said: "They must be men of elastic conscience. Personally I could not do it, because I do not believe in the union's methods. In affiliating with the trade unions they are trying to anticipate the political movement in this country. [He evidently refers to a possible victory of the labor party.] The union will alienate the sympathies of a good many of its members by this move. The British Medical Association does not need to be a trade union to fulfill its objects. Nearly 60 per cent of the profession are members of the association and the turn of events does not perturb us in the least."—London News Letter, *Journal of the American Medical Association.*

Advances in Ovarian Therapy.—A gynecologist, whose name is known from coast to coast, recently commented in the *Journal of the American Medical Association* (February 23) about the cost of ovarian therapy. "It is greatly regretted," he wrote, "that the American products have not been available at prices that justify their preference or at least their being on a parity with the imported material."

Physicians who have read this statement will be interested in the announcement from the Squibb Laboratories that the potency of Amniotin, a physiologically tested preparation of the ovarian follicular hormone, has been increased three-fold and the cost per unit has been reduced to about one-tenth of its former price. For hypodermic administration, Amniotin in Oil is now distributed in one cubic centimeter size ampuls, containing 8,000 and 2,000 International Units per cubic centimeter.

Amniotin Capsules and Pessaries (vaginal suppositories) now contain 1,000 and 2,000 International Units, respectively. The price of these packages is now so low as to compare favorably with the cost of insulin.

The kernel of the scientific outlook is a thing so simple, so obvious, so seemingly trivial, that the mention of it may almost excite derision.

The kernel of the scientific outlook is the refusal to regard our own desires, tastes and interests as affording a key to the understanding of the world.

Stated thus baldly, this may seem no more than a trite truism. But to remember it consistently in matters arousing our passionate partisanship is by no means easy, especially where the available evidence is uncertain and inconclusive.—Bertrand Russell.

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EDITORIALS*

YOSEMITE ANNUAL SESSION

This Year's Annual Session Voted a Success.—The sixty-fourth annual session of the California Medical Association, the third to be held in Yosemite since the founding of the Association in the year 1856, has now taken its place in the long annals of the society. It will be remembered as a session with a registration unusually large, in an environment nowhere to be excelled for its natural beauty, and for meetings at which the scientific papers were of excellent standard, with large and appreciative audiences; and for section conferences where business of exceptional importance was transacted by the delegates in an expeditious, but fraternal manner.

The Hotel Ahwahnee, Camp Curry and Yosemite Lodge, and their cabins and tent-houses, were all taxed to capacity; but everywhere was the spirit of good fellowship in evidence, going far in overcoming some of the occasional inconveniences. The total registration was 951, while at the dinner in the Camp Curry pavilion, given in honor of President Clarence G. Toland, almost twelve hundred guests were seated, with an overflow group of about three hundred at the Hotel Ahwahnee.

The scientific program, as printed in the April issue, was carried through splendidly. The Association is not only much indebted to the guest speakers, but also to the many members who, in the section programs, presented papers of worth on work done in the last and preceding years.

The full report of the transactions of the House of Delegates, now being transcribed by the official stenographer, will be printed in the July number. A perusal of the various items submitted to the House, and the decisions reached on many matters vital to the progress of organized and scientific medicine, should make every member of the California Medical Association realize the important functions of the House of Delegates, when it exercises its responsibilities in the election of officers and the determination of Association policies. To be a member of the House of Delegates is both an honor and an obligation, and should so be regarded by all.

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The Retiring President, Dr. Clarence G. Toland.—The address of the retiring president, Dr. Clarence G. Toland, is printed in this issue as first of the original articles, and its perusal is commended to every member of the Association. The generous reception given to President Toland's remarks show that his personal points of view were in harmony with those of a very large number of California Medical Association members. The Association is deeply indebted to Doctor Toland for many efficient services, which he so unselfishly rendered during his term of office. His visits to numerous component county societies aided greatly in bringing into being a kindlier approach in the discussions of some of the important economic and welfare problems facing the profession in these troublous times. The outpouring of members at the dinner in his honor was a tribute in part to both his work and his genial personality. As he laid aside the cares of his office, he took with him the hearty good wishes of all his colleagues.

* * *

President Robert A. Peers of Colfax.—With the close of the session on Thursday, May 16, Dr. Robert A. Peers of Colfax assumed the office of president. Doctor Peers needs no introduction to members of the California Medical Association who have kept in touch with scientific and organized medicine. His work in his own specialty, and his labors for the Placer County Medical Society and lay fellow citizens, are known to scores of physicians. Up in the Mother Lode country of California, his is a name to conjure with; and for no other reason than that of ever willing, generous and able service for all to whom he could be of aid. He is a representative of the splendid type of the all-around physician more frequently met with, perhaps, in the western than in the eastern states. Doctor Peers has had a

* Editorials on subjects of scientific and clinical interest, contributed by members of the California Medical Association, are printed in the Editorial Comments column, which follows.

long career in organization work, and the example he sets in still modestly acting as secretary of one of the component county societies of rather limited membership may be pointed to as worthy of emulation. All who personally know Doctor Peers are confident that the welfare of the Association, while in his keeping, is in safe hands.

* * *

President-Elect Edward M. Pallette of Los Angeles.—When the new constitution and by-laws of the California Medical Association were adopted at San Diego in the year 1929, the honor of becoming the first speaker of the House of Delegates was placed on the shoulders of Dr. Edward M. Pallette of Los Angeles. At each succeeding annual session, Speaker Pallette was reëlected without opposition. This year, however, the House of Delegates chose not to return him to that office, but to bestow upon him another honor —that of president-elect.

For several years, Doctor Pallette has been vice-president of the California State Board of Health, and in Los Angeles, where he has played an important part in the advancement of scientific and organized medicine, his election to the high office of president-elect meets with universal approval. During his years of service as speaker, he has been a member of the Board of Councilors and Executive Committee; and in these positions his wise counsel will continue to be felt.

* * *

Speaker W. W. Roblee of Riverside.—The new speaker of the House of Delegates is Dr. W. W. Roblee of Riverside, who has heretofore served as member of the Council from the first district. Doctor Roblee, when in the chair, will be found to be an able successor to Speaker Pallette. His decisions may be counted upon to be marked by both clearness and fairness.

* * *

Other Newly-elected Officers.—In the fourth councilor district, the vacancy created by the resignation of Dr. Fred R. DeLappe was filled by the election of Dr. Axcel E. Anderson of Fresno. Other members of the Council and delegates to the American Medical Association were reëlected by acclamation, a tribute to their past services and their personal popularity. These included the following:

First district councilor, Dr. C. L. Emmons of Ontario; seventh district councilor, Dr. Oliver D. Hamlin of Oakland; councilor-at-large, Dr. Harry W. Wilson of Los Angeles; councilor-at-large, Dr. Morton R. Gibbons of San Francisco.

Delegates to the American Medical Association, Dr. Elbridge Best of San Francisco, Dr. Lyell C. Kinney of San Diego and Dr. Fred B. Clarke of Long Beach.

Alternates to the American Medical Association, Dr. Robert S. Stone of San Francisco, Dr. Harry H. Wilson of Los Angeles and Dr. A. J. Scott of Los Angeles.

STATUS OF HEALTH INSURANCE LEGISLATION IN CALIFORNIA

California Newspapers Announce that No Health Insurance Legislation Will Be Enacted This Year.—At the time these comments are being written, the California newspapers are printing Sacramento dispatches concerning the fate of the two major health insurance bills, namely, Senate Bill 454, and what might be called a companion bill in the Assembly, Assembly Bill 1097. Senate Bill 454 in its original form was drafted by the California Medical Association Committee of Six, after authorization by the House of Delegates at the special Los Angeles session, the bill having been submitted to the upper house on April 12 by the Senate Interim Committee (Senators Dan E. Williams of Tuolumne County, Edward Tickle of Monterey County and Leonard J. Difani of Riverside County); while Assembly Bill 1097 was introduced on May 10 as an amendment to a skeleton bill having that number, by Assemblyman H. Dewey Anderson of Santa Clara County, with other sponsors not announced.

At Yosemite the adjournment of the House of Delegates of the California Medical Association took place on Wednesday evening, May 15. Two days later, the newspapers announced that neither of these health insurance bills had much chance of passage at this fifty-first session of the California Legislature. This similar action by the Senate and Assembly was not taken because of advices from, or with the sanction of the California Medical Association Committee of Six that these bills should be withdrawn at this time, but because the legislative reference committees and individual legislators, presumably feeling that the bills could not go on to passage in the turmoil of the last days of the session, in the press of other business, deemed it wise that the measures be not pressed for passage at this session. With the per diem pay to legislators legally coming to a close on May 22, it is stated that the legislature will probably adjourn some day between May 25 and June 1. It is almost safe to assume that neither of these bills will become a law during this fifty-first legislative session. They remain on the calendars, to die there.

* * *

California Senate Appoints a New Interim Committee.—The Senate, two days after the close of the Yosemite session of the California Medical Association, was the first to take up the ultimate disposition of Senate Bill 454, that body having voted that a new interim committee should be appointed, this committee to consist of Senators Dan E. Williams of Tuolumne County, Edward H. Tickle of Monterey County, Leonard J. Difani of Riverside County, William F. Knowland of Kings County, and A. L. Peirovich of El Dorado County, the committee to elect its own chairman. In the above committee, Senators Williams and Knowland will continue as members of the fifty-

second legislature two years hence; but Senators Tickle, Difani and Peirovich must go before their respective districts for reëlection.

* * *

*California Assembly Likewise Appoints an Interim Committee.**—Not to be outdone by their Senate confrères, the Assembly voted, a day later, to bring into existence an Assembly Interim Committee of five members.†

* * *

The Question of Separate and Conjoint Reports, and of Supporting Finances.—Whether these two committees, one from the Senate and one from the Assembly, will join forces and make one study on the needs of a state health insurance system for California, or whether they will act independently, has not been announced. In the present depleted condition of the State treasury, whatever public funds may be allocated for such investigations, will necessarily be of somewhat minor amounts.

The California Medical Association will have spent some $35,000 of its own reserve funds as an expression of its interest in the solution of these problems; but like the State treasury, it is now where it must stop, look and listen before making additional appropriations. Whether federal aid will be forthcoming is also not known, the SERA having already expended more than $60,000 in these California investigations carried on during the years 1934 and 1935. Two years ago, it was stated that several of the large eastern foundations, such as the Milbank, were anxious to take a part in the California surveys; but whether such endowing institutions will now come into the California picture, to aid the two new interim committees, is not known at this time.

* * *

Action of the House of Delegates on the March 2 Special Session Resolutions.—The minutes of the House of Delegates, which will be printed in the July issue, presents the official actions taken at Yosemite. In the meantime it may suffice to state that the stipulations in the special session Resolution No. 2—printed on page 187 of the March,

* Editor's Note.—The California *Assembly Daily Journal* of May 18, 1935, printed Assemblyman Anderson's resolution creating an Assembly Interim Committee to study and bring in a report on the need of a health insurance law in California. It has a double interest in that it incorporates in its first "Whereas" the resolution passed by the Senate, in which that House also created a Senate Interim Committee to take up the work of the Interim Committee of the present or fifty-first legislative session. From the *Assembly Daily Journal* we quote:

RESOLUTION

"The following resolution was offered:

"By Mr. Anderson:

RESOLUTION

"WHEREAS, The Senate of the fifty-first session of the California Legislature adopted a resolution May 17, 1935, in terms and figures as follows:

"WHEREAS, The development of more adequate health services at rates within reasonable reach of self-supporting individuals and families of small and moderate incomes is essential to promote the comfort, health, safety, economic security and general welfare of the people of the State of California; and

"WHEREAS, The committee appointed by the Senate April 19, 1933, composed of Senators Williams, Tickle, Difani and its coördinator secretary, Dr. Celestine J. Sullivan, have performed a distinguished public service by devoting two years of disinterested and arduous work at their own expense to the study of health insurance and the investigation of the high cost of sickness and the preparation of a very valuable report published in the *Senate Daily Journal*, April 12, 1935; and

"WHEREAS, The useful data assembled by the committee show the complexity and magnitude of the questions involved and the fundamental importance of vital underlying problems which affect the life of the commonwealth to such an extent that further study is deemed desirable in order that laws passed by this session or previous sessions of the California Legislature, relating to medical care, may be revised to suit changed conditions and made to conform to reasonable amounts which the tax-paying public can afford; now, therefore, be it

"*Resolved*, That a Committee of Five members of the Senate be appointed by the President of the Senate to continue the study of present methods of medical and hospital care and the economic order under which they operate and the practical application of such laws as now exist or be adopted at the fifty-first session of the California Legislature so that accurate and up-to-date information may be available for the 1937 session of the Legislature; and be it further

"*Resolved*, That said committee shall proceed to organize by the election of one of its members as chairman and by the selection of a coördinator secretary and the adoption of such rules as it shall deem necessary or advisable to enable it to carry into full force and effect the duties herein imposed; and be it further

"*Resolved*, That said committee is authorized to hold public hearings at any place in the State of California at which hearings the people shall have opportunity to present their views to the committee; and be it further

"*Resolved*, That said committee is hereby authorized and empowered to do all things necessary to make a full and complete investigation of the matters herein referred to and to require the production of records, books, agreements, contracts, fee schedules, documents, and papers of every kind; to issue subpenas and to compel attendance of witnesses and to procure testimony. Each of the members of said committee and the coördinator secretary chosen by the committee is hereby authorized to administer oaths and all the provisions of Article VIII of Chapter II, Title I, Part III of the Political Code of the State, relative to the attendance and assemblage of witnesses before the Legislature and committees thereof and during the interval between sessions; and be it further

"*Resolved*, That the committee in order to make a comprehensive investigation of the problem, may accept donations from philanthropic persons, foundations and others interested in the study and investigation and shall expend such donations in carrying out the purposes hereof; and be it further

"*Resolved*, That said committee shall report and make recommendations to the fifty-second session of the Legislature during the session commencing in January, 1937, before the constitutional recess thereof; and

"WHEREAS, The Assembly of the California Legislature has equal interest with the Senate in the health of the people which is the most valuable resource of the State and the most priceless possession of its citizens; and

"WHEREAS, The Senate has appointed a Committee of Five of its members to make a comprehensive investigation in accordance with the terms of its resolution of May 17, 1935; now, therefore, be it

"*Resolved*, That a Committee of Five members of the Assembly be appointed by the Speaker, having the full powers provided in the Senate resolution of May 17, 1935, as embodied herein, to confer and coöperate with the Senate committee in fact-finding studies and the formation of a plan to promote the health and general welfare of the people of California.

"*Resolved*, That the sum of $2,500, or so much thereof as may be necessary for the purpose of defraying the expenses of the committee and the cost of its investigation, is hereby made available and appropriated for the use of the committee out of the contingent fund of the Assembly, and the State Controller is authorized and directed to draw his warrants in favor of the person or persons entitled thereto for such expenditures as may be certified to him from time to time by the chairman of the committee and the State Treasurer is hereby authorized and directed to pay the same.

CONSIDERATION OF RESOLUTION BY MR. ANDERSON

"Resolution by Mr. Anderson read.

"Mr. Anderson moved the adoption of the resolution.

"The question being on the adoption of the resolution.

"The roll was called, and the resolution adopted by the following vote:

"Ayes, 58; noes, 1."

† Editor's Note.—The Assembly Interim Committee, as announced by Speaker Edward Craig of Orange County, consists of Assemblymen H. Dewey Anderson (sociologist and educator) of Santa Clara County, Gordon W. Corwin (orange grower) of San Bernardino County, Thomas J. Cunningham (lawyer and educator) of Los Angeles County, James J. McBride (insurance) of Ventura County, and Ralph W. Wallace (attorney) of San Diego County. This committee will elect its chairman. The occupations listed above in parenthesis are taken from the "Assembly Weekly History."

and page 272 of the May issues—were in no manner modified at Yosemite. At the Yosemite meeting, members of the Committee of Six, who sat in the House of Delegates, stated on the floor that if Senate Bill 454 or Assembly Bill 1097 failed in their final form to measure up to the stipulations outlined in Resolution No. 2, the bills would be promptly withdrawn.

However, the actions taken independently by the California Senate and Assembly, prevent that dilemma from arising.

* * *

The Present Status of the Health Insurance Bill.—For the present, the record of the California Medical Association is that its members have given active coöperation in promoting a cross-section survey of sickness incidence and costs in California, and of having aided in the draft of a bill (S. B. 454) submitted on April 12, which received, however, many amendments, and which in its amended form on May 17, was withdrawn from the Senate calendar. It has been stated that before the legislature adjourns, Assemblyman Dewey Anderson would submit amendments to Assembly Bill 1097, to permit its final printed form to conform in the main with Senate Bill 454, as that measure was originally introduced by the Committee of Six.

* * *

Course of Future Action by the Association.—It now devolves upon the Council to consider the future course of action. The annual meeting of the trustees of the Association has been called for Saturday, May 25, and on that day the Council of the California Medical Association will also convene. At that meeting the future course of procedure will probably be outlined. The decisions reached, in conjunction with the minutes of the House of Delegates, will probably be announced in the July issue.

* * *

Thanks Due to the Committee of Six.—In bringing these comments to a close, it is only proper that attention should again be called to the efficient work performed by the Committee of Six (Doctors Junius B. Harris of Sacramento, Walter B. Coffey of San Francisco, Fred R. DeLappe of Modesto, T. Henshaw Kelly of San Francisco, E. T. Remmen of Glendale and Joseph Catton of San Francisco). Theirs was no easy task, and their faithful services, as well as those of the members of the Advisory Committee, deserve and will elicit the thanks of the members of the California Medical Association.

* * *

Every Component County Society Should Continue Its Study of Health Insurance Problems and Plans.—In conclusion, may not the importance of continued study of sickness insurance be here emphasized? The action of the present legislature has not solved these problems. They will be found facing us two years hence, perhaps in more militant manner than in that of yesterday and today. It is most important, therefore, that every member should acquaint himself with all phases of the subject.

In the larger component societies, medical economic sections, to meet quarterly, bimonthly or monthly, could well be brought into being. In the smaller societies, two evenings each year—one in the spring and the other in the fall—might well be devoted to a discussion of these topics, with presentations by both local and guest speakers. In the larger societies, if economic sections are formed, at least two general meetings of the entire membership should be given over to suitable programs.

A perusal of the speeches made at the Los Angeles special session and printed in this issue,* will at once indicate to the readers what radically different opinions are held by some of our members. It should, nevertheless, be possible, through friendly discussion of insurance system facts in relation to sickness incidence and costs, for members of the profession to meet on a common ground, so that the interests of the lay public and of the medical profession will be both adequately and properly protected. If we are not educated in these matters, we shall find ourselves in the future in unfortunate situations.

OTHER LEGISLATION

The fate of the bills in which members of the medical profession have special interest is still in doubt. Brief mention may be made of several:

Qualifying Certificate Act (A. B. 1552).—This bill will die in committee. Many amendments thereto were submitted, and others suggested and sent to the special committee, whose report appeared on page 317 of the April issue. The House of Delegates at Yosemite voted to instruct the Council to continue its studies for such a law, and to submit the same as an initiative act at a future State election. This recommendation is in line with the advice of the Special Committee when it secured the Council's permission to introduce Assembly Bill 1552, as a means of better provoking suggestions for possible amendments.

* * *

Senate Bill 471: "Relating to Medical and Hospital Insurance Service."—It is stated, when Assembly Bill 1097 (the number of the health insurance companion bill to Senate Bill 454) was being discussed in the Assembly chamber before the Committee on Social Welfare, that Senate Bill 471, introduced by Senator L. J. Difani of Riverside, was plucked from the bottom or near-bottom of the committee file, to pass out to the Senate floor and go on to passage in the upper House. At this writing, Assembly Bill 471 has had its third reading in the Assembly, but is being bitterly contested. Many members of the Association have been consulted in regard to this proposed law. What the end-result will be cannot be foretold at the time these comments are written.

* The speeches made at the special sessions of March 2-3 are printed in this issue, on pages 445-460 inclusive.

A general outline of Senate Bill 471 was given in the following article, taken from the San Francisco *Examiner:*

The California Medical Association has raised objections to Senate Bill 471, which provides for medical and hospital service insurance. The bill has passed the Senate and is on the third reading file of the Assembly.

Chief objection made to the bill, as stated by the Association's representative, is that "it converts the practice of medicine to the business of insurance and profit from the sick."

Protection Not Given

It is also asserted that the bill provides no minimum standards of care for the protection of the patient and gives no authority for fixing such minimum standard and also by implication does not prohibit solicitation, but authorizes it.

The bill, according to the Association, would by implication allow a physician to use a name other than his own if he were an insurer under the act while, it is claimed, such practice is prohibited by the Medical Practice Act.

Held Unnecessary

It is averred by the Association that the bill is unnecessary to control and regulate certain persons and associations in that "the existing laws and court decisions now take care of that."

It is stated by the Association that the bill fails to furnish the insurance department with necessary expert assistants to enforce its provisions. Objection is further stated by the Association in that it is claimed the bill would result in "commercialism of medicine and will not even tend to solve the problems connected with the cost of sickness." The statement is made for the Association:

"If it is deemed necessary by the insurance department that hospital service insurance be regulated, this can be done by amending the bill to delete all professional medical service."

* * *

Physicians' and Hospital Records (A. B. 2158).—This bill would have given attorneys the right, without let or hindrance, to inspect and copy physicians' and hospital records when "there shall be either pending or contemplated litigation, in which said records will, in the opinion of said attorney, be helpful to the cause of his client." This bill deservedly died in committee.

* * *

So-called Antivivisection Bill (A. B. 2401).—In popular parlance this measure, proposed by the business manager of the Butchers' Union of Alameda, was known as the "dog bill," and in the "committee pound" it went into a quiet death. Some of its proponents now talk confidently of resorting to an initiative to bring about the enactment of such a law. If that happens, the dogs of war will surely be unleashed.

* * *

Assembly Bill 1037: "An Act to Safeguard the Public Health by Regulating the Use of X-Rays on Living Persons in California."—The object of this bill, introduced by Assemblyman J. E. Peyser of San Francisco, is to confine the use of x-rays to reasonably qualified persons. It would do away with the use of such a potent agent as x-rays by beauty-parlor operators or shoe-fitting establishments. While recognizing the rights of physicians and others, its provisions would prevent persons, not qualified, from receiving licenses to use this modality. The licensing power was placed under the California State Board of Health instead of under the State Board of Medical Examiners, in deference to osteopathic and other groups who might object to the State Medical Board.

* * *

County Health Insurance Systems (A. B. 2397).—This is the Heisinger bill. Its provisions for medical service have been amended out of the bill, but it still contains provisos that could be a real menace to medical standards.

* * *

Restrictions on Granting Doctor and Other Degrees (A. B. 1765).—The racket that has arisen through lax laws governing the incorporation of educational institutions having the right to grant doctorate and other degrees was briefly commented upon, on page 273 of the April issue. Assembly Bill 1765 places additional safeguards on the granting of degrees, diplomas and certificates. The measure has passed out to the Assembly floor and may go on to passage. The amendments to existing statutes proposed in Assembly Bill 1765 would inflict no hardships on legitimate institutions, but would go far in doing away with fly-by-night rackets.

* * *

Much might be written of a dozen or more measures of special interest to groups of members, but it is not possible, in this short time before going to press, to prognosticate the outcome. Comment on the results, therefore, will be held over for the July issue.

SPECIAL SESSION SPEECHES ON HEALTH INSURANCE

Speeches and Remarks Made at the Special Session of the California Medical Association House of Delegates Printed in This Issue.—The official minutes of the special session of the House of Delegates of the California Medical Association, held in Los Angeles on March 2 and 3, 1935, were printed on pages 194 to 207 of the March issue. At that time the speeches by delegates had not been transcribed, and since then special annual session program and other features have delayed their publication.

In this issue will be found most of the speeches made at the special session, on both sides of the health insurance question.* The attention of readers is called to these discussions because the action taken by the House of Delegates at that time, before its members voted favorably upon the outstanding resolution (Ingber Resolution No. 2) of that special session, was more or less swayed by the arguments put forth. The remarks made by delegate speakers are as pertinent today as then, and to members of the California Medical

* The special session speeches are printed in this issue, on pages 445-460.

Association they should still have special interest and value because the opinions then presented reflect the points of view not only of the individual speakers, but of considerable groups of members throughout the State, holding to somewhat similar outlooks. Health insurance problems will continue to have a prominent place in medical and lay thought for years to come. A perusal of the speeches printed in this issue can be thought-stimulating, if readers will but ask how they themselves would answer the various statements put forth by the delegates who spoke on the several phases of the topic, and for the consideration of which the special session was convened at Los Angeles on March 2 and 3. For two days the members of the House listened with marked attention to the debates. Now, members-at-large, in leisure moments, may well review the proceedings in retrospect. Take the time, therefore, to read these speeches. If you do not approve of what is there said ask how you yourself would answer, or what kind of a presentation you yourself would have made, to express your own understanding of the various problems.

EDITORIAL COMMENT*

HYPOGLYCEMIA IN DIABETES

It is well known that depancreatized animals develop hyperglycemia, and that this hyperglycemia may be controlled or dropped to normal or subnormal levels by the artificial injection of insulin. It is not so well known that a certain number of these depancreatized animals die in a state of hypoglycemia without having had any artificial injection of insulin. Autopsy on these animals reveals a marked fatty degeneration of the liver.[1]

The existence of a sufficient amount of functioning liver tissue is necessary to maintain sugar up to normal or hyperglycemic levels. There is abundant evidence to support the idea that hepatic damage causes hypoglycemia in non-diabetic animals.[2] Furthermore, we conclude from the work of F. C. Mann and T. B. Magath that when a dog is depancreatized and hyperglycemia results, and then the liver is removed, the blood sugar falls and the dog dies in a state of hypoglycemia. These investigators say: "The experiments prove conclusively that the liver is absolutely necessary for the maintenance of the blood-sugar level in the hyperglycemic animal in the same manner as in the normal animal. The increase in blood sugar following pancreatectomy is dependent on the presence of the liver. Without an adequate amount of functioning liver tissues, the increase in blood sugar, following pancreatectomy, could not occur."

It is the general opinion that the typical hyperglycemic response of the depancreatized animal is much better when the animal is fed pancreas by mouth. That this is not due to any absorption of insulin from the intestine is also well known. It is suggested that the external enzymes of the pancreas have some beneficial effect on these animals, and that a possible cause of the fatty degeneration of the liver in depancreatized animals is the absence of the pancreatic enzymes.[3] In support of this idea, non-diabetic animals with permanent pancreatic fistulae show this fatty degeneration of the liver with the resultant hypoglycemia. Such animals are greatly hypersensitive to insulin.[4]

Paralleling this experimental work, I. T. Zeckwer [5] reports the case of a man who was diabetic. He had been taking insulin for some time, but gradually developed an increased sensitivity to the insulin, so that it was withdrawn. A condition of hypoglycemia persisted, which was relieved only by the intravenous injections of glucose. He finally died in a state of hypoglycemic shock. Autopsy revealed a marked fatty degeneration of the liver, a complete obstruction of the pancreatic duct with stones and a marked atrophy, not only of the isles of Langerhans, which accounted for his diabetes, but also of the structures which normally secrete pancreatic juice. The hypoglycemia was apparently due to the degeneration of the liver, and the degeneration of the liver was due to the absence of pancreatic enzymes.

It is suggested that when the liver is damaged through the loss of the external secretions of the pancreas, hypoglycemia may result in a patient with diabetes, even in the absence of treatment with insulin.

College of Medical Evangelists.

W. E. MACPHERSON,
Loma Linda.

* This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comment by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California and Nevada Medical Associations to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

1 Fisher, N. F.: Am. J. Physiol., 67:634, 1923.
2 Mann, F. C., and Magath, T. B.: Arch. Int. Med., 37:797, 1923.
3 Hershey, J. M., and Soskin, S.: Am. J. Physiol., 98:74, 1931.
4 Berg, B. N., and Zucker, T. F.: Proc. Soc. Exper. Biol. and Med., 29:68, 1931.
5 Zeckwer, I. T.: Arch. Int. Med., 54:330.

The First "Skyscraper" Hospital in Europe.—The new Beaujon Hospital has just opened its doors in Paris. An event that would attract little attention in the United States is hailed here as the beginning of a new era in hospital construction. The majority of continental hospitals are composed of a group of one to, at the most, three-story buildings, scattered over a relatively large area. The new Beaujon Hospital is eleven stories in height and has a capacity of 1,100 beds, with a large out-patient department. There are only fourteen beds in each ward, and four of such wards form a service under the charge of a single attending physician. The laboratories and rooms for research work are in immediate proximity to each service. The cost of construction has been $4,500 per bed and it is hoped that the cost of maintenance may be materially decreased through centralization in one building.

We spend six times as much for funerals and tombstones each year as we appropriate for public health service.—James M. Parrott, M.D., State Health Officer, North Carolina.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section (Adv. pages 2, 4 and 6).

A MESSAGE FROM PRESIDENT PEERS

To the Members of the House of Delegates—Greeting:

Your President wishes to express to the House of Delegates collectively, and to the members of the House individually, his extreme pleasure because of the manner in which the Delegates at the Yosemite meeting showed, by their actions, that they place the interests of organized medicine, and the interests of the public, whom they serve far in advance of private desires, personal gain, or of personal ambition.

During the past years it has seemed, at times, to your President that, in the heat of argument, in the great differences of opinions held by members of the Association and by its duly-elected representatives, the interests of the profession might be momentarily forgotten. The word "momentarily" is used advisedly because, in his thirty years' experience in medical society work, he has learned that only an infinitesimal proportion of the Association members is actuated by other than the highest motives when engaged in its activities. But, in the heat of battle, in the clashing of different opinions and philosophies, actions may be taken which would work immeasurable harm to the profession and which, on cooler thought, are regretted. It is refreshing to your President, therefore, to see the "cooler thought" prevail before rather than afterwards.

In the trouble and turmoil of the past few years, you have seen many old maxims, many time-tried truths swept into the discard, and untried theories adopted in their place. The members of the 1935 House of Delegates of the California Medical Association have shown by their actions that the old maxim, "United we stand, divided we fall," still serves as a guide.

Your President knows only too well, and appreciates only too thoroughly, just how many heartaches were incurred, and how much self-sacrifice was accepted, by individual members at Yosemite, in order that the best interests of the medical profession might be served. He is immensely heartened by this evidence of devotion while, at the same time, he sorrows at its cost. He has increased confidence in the future, and is encouraged by the increasing evidence of the solidarity of the profession. Let us continue this evidence of coöperation and harmony. Your President is at your service.

Cordially and fraternally,

ROBERT A. PEERS, *President.*

SIDELIGHTS ON THE YOSEMITE ANNUAL SESSION

DINNER TO PRESIDENT CLARENCE G. TOLAND

The dinner tendered to President Clarence G. Toland was held on Tuesday evening, May 15, in Camp Curry Pavilion at Yosemite National Park. The dining-hall filled rapidly with the twelve hundred members and guests who had gathered to do honor to the retiring president. In spite of the handicaps incident to caring for so large a group in advance of the regular Park season, and at a time when many of the Park personnel were still becoming acquainted with their respective duties, the dinner was served with dispatch. It early became evident, from the general hum of conversation and laughter, that the members and guests had responded to the beauties of Yosemite Valley in full measure, and that with extra attractions such as the firefall, which was postponed from nine to the nine-thirty hour, the after-dinner speeches, even though scheduled on the menu cards as being each of only five minutes' length, would be more in the nature of gestures than of performance. And so it turned out to be. Toastmaster Kress, in order to make himself heard, made megaphonic efforts to reach all parts of the pavilion, but with only faint success. The humor of the situation appealed to all, however, and the speakers, as they were announced, received welcoming rounds of applause, although their kindly expressions were heard by only a few who sat close to the speakers' table. Council Chairman Kelly was equal to the occasion, and gave his speech in the sign language. Immediately after dinner the guests adjourned to witness the spectacular firefall, after which the light fantastic was tripped in the adjacent dancing pavilion.

Excerpts from the printed menu cards follow:

CALIFORNIA MEDICAL ASSOCIATION

SIXTY-FOURTH ANNUAL MEETING

YOSEMITE NATIONAL PARK

MAY 13-16, 1935

PRESIDENT'S DINNER

Honoring President Clarence G. Toland, M.D.

"Five Minute Courses"

J. S. MC LESTER, M.D.
President-Elect, American Medical Association

"Titles of honor add not to his worth
Who is to himself an honor to his titles."
Lady's Trial, Act I, Sc. 3

E. STARR JUDD, M.D.
Past President, American Medical Association

"A great man is made up of qualities
That meet or make great occasions."
Study Window—Lowell

ROBERT A. PEERS, M.D.
President-Elect

"An honest man, close-buttoned to the chin,
Broadcloth without, and a warm heart within."
Cowper

T. HENSHAW KELLY, M.D.
Chairman of the Council

"He mouths a sentence as curs mouth a bone."
The Rosciad, L. 322

PRESIDENT CLARENCE G. TOLAND, M.D.

"He hath a heart as sound as a bell
And his tongue is his clapper,
For what his heart thinks his tongue speaks."
Much Ado About Nothing, Act III, Sc. 2

* * *

ENTERTAINMENT

"To mourn a mischief that is past and gone
Is the next way to draw new mischief on."
Othello, Act I, Sc. 3

PARK STROLLERS—

As and when you see them during dinner.

FIREFALL FEEDING BEARS

DANCING

"Most glorious night!
Thou wert not sent for slumber."
Don Juan, Canto II, St. 152

?

"Diverse men have diverse recreations and exercises."
Burton, Anatomy of Melancholy

* * *

MENU

"O hour of all hours, the most bless'd on Earth,
The blessed hour of our dinners."
Lucile, Pt. I, Canto II, St. 23

Fruit Cocktail

Green Olives Crisp Celery Hearts

Consomme, Julienne

Poached Salmon with Egg Sauce

Sirloin Steak with Mushroom Sauce

Potatoes au Gratin Buttered New Peas

Mixed Green Salad with French Dressing

Hot Dinner Rolls

Biscuit Tortoni

Demi-tasse

Camp Curry, Yosemite National Park - - May 14, 1935

* * *

LUNCHEON OF THE COUNTY SOCIETY SECRETARIES

President-elect Peers presided at the combined state and county officers' luncheon, which was held at the Ahwahnee Hotel in the Yosemite Valley, Wednesday noon, May 15. There were present most of the councilors and state officers and several officers of the component county societies.* Following introductory remarks by the president-elect, short addresses were given by many of those present, including President Toland, who outlined the work of the past year and paid tribute to the work of the councilors and to Secretary Warnshuis; General Counsel Peart, who discussed legal matters of interest to the component county societies, and warned of the pitfalls which await the unwary who proceed without proper legal advice; Dr. J. B. Harris, who sketched legislative problems and difficulties which confront organized medicine, as seen by the chairman of the Legislative Committee; and Dr. C. A. Dukes, who spoke on the present and contemplated activities of the Department of Public Relations.

At this point Past President O. D. Hamlin, who arrived late, was tendered a warm greeting by those present.

Dr. F. C. Warnshuis, secretary-treasurer and director of the Committee on Public Relations, explained how the state office can serve the county officers and the individual members of the medical profession. He urged all county officers to call upon the central office of the Association at any and all times, and to carry back to their members the message, that he and the personnel of his office are willing and anxious to be of service at any and all times. Secretary Warnshuis then presented Mr. Milton Silverman, who has been serving the society as publicity agent for the past two months.

Brief discussions by Secretary Moore of the Alameda County Medical Society, Doctor Strickler, first vice-president of the San Francisco County Society, Doctor Butler of Sonoma, Doctor Cushman of Mendocino County, and others, followed. The meeting was closed by remarks from the editor, Dr. George H. Kress.

It was the general opinion of all present that the importance of meetings between the state officers and the officers of the component county societies has not been sufficiently stressed. It was generally agreed that, instead of being merely a secretaries' luncheon, it should be a luncheon to all county officers. The value of such meetings in promoting a better understanding by the members of the California Medical Association,

* Present were eighteen state officers and seventeen officers of component county societies.

through the county society officers, of the responsibilities and activities of the state officers, and in providing an equal opportunity for the officers of the California Medical Association to become better acquainted with the needs and problems of the county societies, was particularly stressed. Also, Doctor Warnshuis' suggestion for a mid-winter meeting of the officers of the California Medical Association and the officers of the component county societies where such problems could come up for discussion, received much favorable comment. R. A. P.

* * *

FIRST ANNUAL REUNION OF PAST-PRESIDENTS

This, the first of what it is hoped will become an annual reunion of the past presidents of the California Medical Association, was initiated by an informal breakfast in the alcove of the main dining-room of the Ahwahnee Hotel at 7:30 o'clock on the morning of May 14. By direction of the Council, President-elect Robert A. Peers presided. Of the eleven past presidents in attendance at the annual convention, nine, or 82 per cent, attended. In addition to the following past presidents, George H. Kress (1917), C. Van Zwalenburg (1919), John H. Graves (1922), Edward N. Ewer (1926), William H. Kiger (1927), Lyell C. Kinney (1929), Morton R. Gibbons (1930), Junius B. Harris (1931), and George G. Reinle (1933), the following invited guests were present: Dr. James S. McLester, president-elect of the American Medical Association, and Dr. C. G. Toland, president of the California Medical Association.

Following the breakfast, Chairman Peers stated that many members of the Council at the convention held in Riverside, feeling that we could ill afford to lose the benefit of the experience and counsel of our past presidents, and realizing also that some recognition should be extended them for their previous services, were moved to instruct the secretary to arrange for a meeting of our distinguished former officers at some time during the 1935 session. In accordance with these instructions, Secretary Warnshuis arranged the Tuesday morning breakfast.

After stating that he hoped this would become an annual event and that out of the meeting there would grow a permanent organization to be known, perhaps, as the "Past Presidents' Club," the chairman introduced Dr. James S. McLester, president-elect of the American Medical Association, who delivered a greeting from that body, and spoke briefly upon the subject of medical economics.

Following Doctor McLester's remarks, there were addresses by each of those present, commencing with the senior past president present, Doctor Kress, and then the junior past president, Doctor Reinle, and President Toland. Everyone reiterated the hope of the chairman, that the meeting would result in the formation of a permanent organization.

The undersigned looks forward with pleasant anticipation to the reunion in Coronado in 1936, and hopes that there may be a record attendance of 100 per cent.

ROBERT A. PEERS.

* * *

MÊLANGE

The following observations are intended to impart to non-attendants a few of the outstanding features that characterized the Yosemite session. They reflect some of the fraternal and social activities that enhance the attractions of our annual sessions and are not recounted in the official minutes.

* * *

An orchestra of fifteen pieces played California and popular music while the audience was assembling for the opening general session. At the hour of 10 a. m. on Monday morning when some 900 members were assembled, President Toland introduced Mrs. Fred B. Clarke of Long Beach who led the audience in singing "I Love You, California." By her gracious compliment to President Toland with her cultured voice, Mrs. Clarke fixed the keynote of the entire session—good fellowship and genial camaraderie.

At the President's Dinner on Tuesday night, 1,138 were served in the main dining room. There was an overflow of 235 in the Ahwahnee dining room and over 600 were served at Yosemite Lodge. Doctor Kress, as toastmaster, was in his customary efficient fettle. During the dinner Doctor Barnard of Los Angeles supplemented—no, exceeded the Park Strollers—by his artistic renditions on the accordion. "Barney" is appointed as master of ceremonies at the 1936 Coronado meeting. Would we could describe the ladies, their gowns and charms. Surely was a style show and a lovely moonlight night. All too soon the dance orchestra "signed off."

* * *

Doctor Don Tressidor, president of the Ahwahnee Curry Company, Manager Goldworthy, Assistant Manager Rossington—in fact, all of the Park's official family were indefatigable in seeking to supply every want.

* * *

"This night was not made for slumber"—so the president's program read. Just 1,600 agreed.

* * *

Woman's Auxiliary—certainly the session would have been somewhat quiet were it not for their inspiring initiative. California medicine needs, yea requires, such feminine inspiration. Every acknowledgment is made for their coöperative assistance.

* * *

The last paper on Thursday afternoon in the Surgical Section held an audience of fifty members. In its two sessions the House of Delegates devoted nine hours in deliberating association problems and policies. Reference Committee Nos. One and Two devoted all of Tuesday and Wednesday in hearings, reviewing reports and drafting recommendations. Every member is indebted to these delegates for their unselfish and untiring service. Watch for the July issue which will contain the minutes, and be sure to read them.

* * *

The Council held five sessions, the Department of Public Relations, two.

* * *

Much credit is due the officers of the Woman's Auxiliary for the splendid programs of that organization and for their aid in the social functions. Mrs. Loren Chandler broke the golf course record for women. Her card of twenty-six was certified to by "Yank."

In spite of ten feet of snow on Glacier Point, 4,000 feet above the floor of the valley, the Park management put on the "Firefall" every night, a beautiful spectacle.

* * *

Many members failed to take the trouble to register—our estimate of attendance, 1,600, is based on hotel and camp reservations.

* * *

The Cancer Commission Conference on Sunday morning was attended by forty-seven members. This conference is an important feature of the program and is creating more interest each year.

* * *

Our sixty-fourth annual session is now a matter of record and a memorable occasion for those who attended. Plans are already underway for our sixty-fifth session. Coronado in 1936 is now our watch-word. Plan to attend. F. C. W.

STATE AND COUNTY SOCIETY ACTIVITIES

SIXTY-FOURTH ANNUAL SESSION

In Yosemite National Park, midst a setting of nature's making, our Association held its sixty-fourth annual session on May 13-16, under the presidency of Clarence G. Toland.

On Sunday, May 12, under the auspices of our Cancer Commission, some fifty-one members engaged in a Pathological and Radiological Conference. The Council held its first meeting Sunday evening.

Beginning with the opening general meeting to the last session on Thursday afternoon, some 1,600 members and their friends were participants in the scientific and social programs. Had accommodations been available, a registration of 2,500 would have been recorded.

The official minutes will appear in the July issue. Advance announcement is made, however, of the following elections:

President-elect—Edward M. Pallette of Los Angeles.

Speaker of House of Delegates—William W. Roblee, Riverside.

Vice-Speaker of House of Delegates—John H. Graves, San Francisco.

Chairman of Council—T. Henshaw Kelly, San Francisco.

Secretary-Treasurer and Director of Public Relations—F. C. Warnshuis, San Francisco.

Editor—George H. Kress, Los Angeles.

Councilors—First District, C. L. Emmons, Ontario; Fourth District, A. E. Anderson, Fresno; Seventh District, O. D. Hamlin, Oakland; Councilors-at-Large, Harry H. Wilson, Los Angeles; Morton R. Gibbons, San Francisco.

American Medical Association Delegates—Elbridge Best, San Francisco; Lyell C. Kinney, San Diego; Fred B. Clarke, Long Beach.

American Medical Association Alternates—Robert S. Stone, San Francisco; Harry H. Wilson, Los Angeles; A. J. Scott, Los Angeles.

Coronado was chosen as the 1936 meeting place.

The California American Medical Association delegates were unanimously instructed to place in nomination the name of Dr. George H. Kress for the vacancy on the Board of Trustees of the American Medical Association. Watch for the July issue for complete details of this annual session.

* * *

DELINQUENTS

By-Law provisions prescribe that every member whose current dues remain unpaid on April 1 shall be placed on the suspended list. Such a member loses all of his membership benefits and his name is removed from this publication's mailing list. Reinstatement may be obtained by paying the annual dues to the county secretary.

On April 1, this year, 890 members became suspended. Since then 184 have been reinstated. County secretaries have been commendably diligent in collecting and remitting dues. They can render additional service by calling upon their delinquent members and inviting them to reinstate themselves.

Out of some 10,000 physicians in the State, 5,159 are affiliated with their county and State organizations. It is estimated that there are some 1,500 physicians eligible for membership who are not members. The Council invites every member to make an effort to secure the affiliation of these non-members. Urge your fellow physician who is not a member to join his county society in order that our Association may represent at least 80 per cent of the eligible physicians in California.

* * *

THE NEED OF A WOMAN'S AUXILIARY

A number of the members of the medical profession, particularly those who have not been active in the organization field, have expressed doubt as to the need of a Woman's Auxiliary to organized medicine. To those who carry the burden of the duties of office, there comes a realization that there is a necessary and vital place which the wives of doctors can fill.

In these days of changing social conditions and the development of a new social philosophy, there must be created some link or liaison between our organized units and society in general.

The busy doctor does not have the time to make necessary contacts with various legislative bodies, with the press and with all the numerous organizations that exist in any given community. These groups are interested in the problems of medicine and we doctors should be interested in their problems. We are often condemned for our narrowness of community vision. We have failed often to present to the community our work, our beliefs, our policies and our standards.

Each county society needs an auxiliary for this definite community objective—rather than for social purposes. Persons eligible for membership are: Doctors' wives, mothers, sisters, and daughters.

We invite the interest of doctor's wives so that they may be auxiliary not only to the medical profession but also to the public.

* * *

AMERICAN MEDICAL ASSOCIATION ECONOMIC CONFERENCE

At the February special meeting of the American Medical Association House of Delegates a resolution was adopted directing the Bureau of Economics to study and devise a plan or plans that would enable county and State units to provide medical care to certain groups of people and to submit a report at the June meeting of the American Medical Association.

The executive officers and the director of the Bureau of Economics issued a call for a conference to be held in Chicago on April 27. Some twenty-five states were invited to send representatives. Such an invitation was received by the California Medical Association. Our Executive Committee appointed Dr. Benjamin Black of Oakland as California's representative. By request Doctor Black has prepared the following general report. Further reports will appear in *The Journal of the American Medical Association*. Our members are indebted to Doctor Black for his time and services and expressions of appreciation are hereby recorded. Doctor Black's report follows:

To the Executive Committee of the California Medical Association:

I received Secretary Warnshuis' note of April 29, 1935, this morning just after my arrival home. The trip was pleasant. I left here as scheduled on Thursday evening, arriving in Chicago late Friday afternoon and left there last night at 6:15 p. m., reaching here before 9 a. m. this morning. It was a rather difficult trip but it does permit one to cover territory in record breaking time.

There were probably twenty-five physicians representing as many county or state societies and a number of lay secretaries representing such associations in attendance. In addition, Doctor Bierring, president of the Association, Doctor West, Doctor Fishbein, Doctor Hayden and others spent part of the time with us. The conference convened rather promptly at 9:30 a. m. under the chairmanship of Dr. R. G. Leland and continued until about 5:30 p. m. in the afternoon, running through the noon hour, as we all had luncheon together. The conference was rather well planned and it began with a free discussion of the various medical plans including special fee schedules that have been adopted, plans for the care of the indigent, particularly the Iowa plan, whereby specified sums are paid quarterly through the county medical society from the particular unit of government having to do with indigents; also plans having to do with pre-payment of medical care where medical service bureaus had been set up as in Fulton County, Georgia, largely covering the practice in Atlanta; likewise the hospital association plans in the State of Oregon and similar plans being worked out by the State of Washington. A formal presentation of the plan recently adopted by the District of Columbia was presented by Doctor Wilson and Mr. Garrett. The Wayne County, Michigan, plan was presented, as were all sorts of minor activities classified under the names of plans by various other persons speaking for county societies. This included, as you will appreciate, the regulations governing clinic and dispensary admissions, the manner of handling emergency relief to physicians, and other allied activities in which county societies formally participated.

I was invited to present the Alameda County Plan which I did informally, but left a rather carefully prepared state-

ment of the plan and its operation for the purpose of record. I also presented in less detail the San Diego County Plan, and made reference to the work being done in San Joaquin County, Fresno County, and Los Angeles County, particularly the so-called San Fernando Plan.

I left with them such information as I had covering more detail than the discussion would permit.

One was impressed with the fact that from the reports it would appear that almost every type of service is being supplied through county medical societies from an admission bureau which also handles pre-payment and post-payment of medical bills as found in the District of Columbia to frank voluntary periodic payment basis plans as found in Atlanta, Georgia. The officials of the American Medical Association seemed very anxious to secure all of this information. There was no critical attitude manifest against any of the proposals submitted and the entire conference freely discussed each proposal as it was submitted, asking questions for purposes of enlightenment with an apparent intense desire on the part of each to understand the movement which seems to be going on throughout the country.

It was proposed in the general discussion that the office of the American Medical Association would digest these various proposals for the purpose of making a submission to the House of Delegates in June. It became evident in the conference that the American Medical Association could not rightfully adopt any plan with the idea of standardizing such an activity in all the counties covered by the Association. The conference passed but one resolution which in effect stated that plans now in operation by county societies or that were contemplated, should comply with principles adopted by their respective State Associations which in the annunciation of principles would follow the general policy laid down by the American Medical Association.

In addition to the ten principles adopted by the House of Delegates in Cleveland in 1934 for the guidance of county medical societies in the conduct of medical service experiments, it was recommended that the following principles be incorporated for any society that contemplated the development of a plan for local application:

1. That a preliminary study be made to determine the necessity or need for any change.
2. That the patient should have freedom of choice of physician.
3. That the plan should be completely controlled by the county medical society. This did not require that all the officials conducting the plan should be physicians, but that sufficient physicians should be on boards of directors or otherwise in control to write the policy.
4. That medical fees for low income groups should be based on ability to pay rather than minimal fee schedules.
5. That there should be a definite plan for a fair determination of the patients' ability to pay.
6. That there should be some centralized system of records and bookkeeping.
7. That any plan should contemplate complete medical service.
8. That the administration of any plan should provide for a service charge for operation of office and should also provide reserve for emergencies or catastrophic loads.
9. That there should be recognition of standing of medical specialties and resistance to exploitation by corporations of any type.

There was presented to each member of the conference a suggestive outline relative to the preparation of a medical society plan covering in some detail these points.

It is my own opinion that the conference was very valuable; that it allowed, perhaps, for the first time, a complete and full discussion of the various so-called plans in operation. I profited greatly. My own participation was well received and many comments were made upon *all* of the medical activities in California, particularly the Alameda County Plan as presented, the standards adopted by the State Association, and there was considerable discussion relative to the proposed compulsory insurance bill now pending before legislature.

B. W. Black, M. D.,
Representative for California.

* * *

POSTGRADUATE CONFERENCES

The second postgraduate session in our course was held at Riverside last night and it was a complete success notwithstanding the fact that the Southern California Medical Association held a two-day session last Friday and Saturday at Arrowhead Springs and the State meeting coming next week. We had over a hundred men in attendance.

Some good clinical material was supplied and the instructors made good use of their opportunity. I would strongly urge other societies undertaking such a course to insist that the teaching be clinical rather than didactic. Our Riverside meeting was a distinct improvement over the San Bernardino one where cases were not furnished.

Very truly yours,
W. W. Roblee, M. D.

AMERICAN MEDICAL ASSOCIATION MEETING

The annual meeting of the American Medical Association will be held in Atlantic City the week of June 9. The following California Fellows appear on the scientific program: Melverton E. Trainor, Los Angeles; Maurice L. Tainter, San Francisco; Windsor C. Cutting, San Francisco; Andrew B. Stockton, San Francisco; E. Hines, San Francisco; Paul D. Foster, Los Angeles; William E. Stevens, San Francisco; John C. Wilson, Los Angeles; Pierre J. Walker, Los Angeles; F. L. Reichert, San Francisco.

* * *

PHYSICIANS' CONTRIBUTIONS OF SERVICES

The Council has directed that information be obtained that will disclose the sum of money represented by the services that are being rendered by physicians on the staffs of county hospitals. These doctors receive no remuneration for their services to the patients in county hospitals. They are rarely given recognition for their services by those in control, and the public does not know that no payment is made to the attending and visiting physicians. It is felt that the public should be informed.

A questionnaire covering the subject was sent some two months ago to every county society for the urpose of securing this information. To date fifteen questionnaires have been returned. While not wholly accurate and in some instances incomplete (because no records are kept), the returns supply a general insight as to what the profession is contributing in services for which they receive no returns. The following figures deal with fifteen counties and do not include San Francisco. They do include Alameda and Los Angeles counties.

Cases admitted to county hospitals	109,669
Out-patient departments	736,744
Operations performed	45,130
Surgical fees equivalent	$2,749,222.00
Medical visits equivalent	$574,323.00
Medical clinical equivalent	$433,345.00
Obstetrical fees equivalent	$55,300.00
Total services in fifteen counties	$4,509,450.00

These figures are based on fifty-cent clinic visits, two-dollar medical visits, and an average charge of $50 for operations.

Annual reports of hospital boards and officers stress in considerable detail the services rendered by their hospital. Scant and often no reference is made, nor is recognition given to the services rendered by the attending staff. This is an injustice. It should be remedied. The suggestion is made that hospital staffs draw attention to this fact and respectfully request the hospital management to prominently acknowledge to the public the services and its value that the medical staff is contributing to the county.

While this comment relates to county hospitals it also is pertinent to private hospitals admitting non-paying patients. Contribution in services by physicians in almost every community exceeds the public's contributions to Community Chests—often threefold. Cite these figures to your hospital management in order that full credit may be given where credit is due.

* * *

PUBLICITY

The development of sound public opinion in regard to scientific and preventive medicine is one of the responsibilities of county and state medical organizations. Much of the public's misconception in regard to disease and treatment is largely due to misinformation.

During the past three months the Secretary's office, through the Association Publicity representative, Mr. Silverman, has been releasing four articles a week to some 250 California newspapers. These releases consist of 200 to 300 words that set forth accepted facts regarding diseases, treatment, or preventive measures. The public is being furnished with dependable facts.

Clipping returns indicate a wide publication of these releases. Many personal inquiries from lay people have been received; one day there were seven such

inquiries. The following letter reveals that which is being accomplished by this publicity activity:

To the California Medical Association:

Through the press, I have been informed of a discovery made by a member of your organization for the growing of undeveloped children through the use of insulin injections.

The doctor of my boy, who is very small for his age, is very much interested in this matter and has asked me to write you as he does not know English. He would be very much obliged if you would send us details of the treatment and results you have obtained.

I am writing you by air mail and beg you to reply the same way and I will gladly refund the postage or any other expenses.

Thanking you in advance, I beg to remain,

Yours very truly,

S. E. ALTAMIRANO.

Address: Salvador E. Altamirano, Convención 1220, Montevideo, Uruguay.

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AUTOMOBILE ACCIDENTS

In 1934 some 36,000 persons were killed and nearly a million injured by reason of automobile accidents. This is an increase of 16 per cent over 1933. Speed is credited as the greatest factor. Of the drivers involved, 3.16 per cent are reported as being intoxicated. Five out of every eight pedestrians killed were involved while crossing in the middle of the street, crossing against signals, or darting from behind cars.

Bill Holman proffers the following suggestions:

Check the wheel; make sure that a loose nut is not holding it.

Do not race trains to crossings. If it is a tie, you lose.

Beware of "green" drivers on red lights.

If you must have a blowout, have it at home.

A pedestrian is a man who missed the payments on his car.

A wheel in the hand is worth two in the head.

As the sun goes down, cut your speed.

Every automobile driver must be made to become a safe and sane driver. Doctor, you can set an example.

* * *

WORTH PONDERING OVER

The borderline 'twixt faith and fanaticism is indistinct. Likewise, that between salutary self-interest and sordid self-indulgence.

* * *

Cynicism subtly employed, is often mistaken for argument.

* * *

"Facts" are less stubborn than are the self-deceived who claim to be in possession of them.

* * *

There is in existence a slogan, "Look up not down, look out not in, look forward not backward, and lend a hand."

This may be modernized as follows:

Look out to avoid danger.

Look in before denunciations of others or approbation of self.

Look up if studying the stars or watching for an airplane.

Look down when negotiating a perilous trail.

Look forward, as a rule, lest one should inadvertently bowl over an approaching pedestrian, but glance backward from time to time if you reside in Washington, Chicago, or Sacramento, and lend a hand to the deserving.

* * *

"We see in the future a dawn of brighter hope for mankind, of better health for men and women, of happy, sturdy growth for little children. Toward this dawn that is to come, the men of medicine and scientists are moving; the thousand of research workers in their practices and clinics. With endless patience and devotion they search, in many lands, but with a united purpose, that mankind may have life more abundantly. In the field of preventive medicine alone, they have brought us marvelous victories—victories over typhoid and scarlet fever, diabetes, diphtheria, smallpox, yellow fever. And in this future dawn, man shall live in joyful health and vigor through his full span of life by reason of the services rendered by the scientific man of medicine."

* * *

Axioms of yesterday fall before the revelations of today.

MINUTES OF THE HOUSE OF DELEGATES

ANNUAL REPORT OF THE COUNCIL*

Mr. Speaker and Members of the House of Delegates:

The Council submits this report, transmitting to the House of Delegates the principle features of the work of the Council and of the Association during the year 1934-1935.

An extraordinary demand has been made upon the Council during the past year by the many unusual matters that have arisen that have had to be met by the best efforts of this Council. Nine meetings of the Council have been held during the year instead of the customary two or three sessions. The minutes of these meetings have been published in CALIFORNIA AND WESTERN MEDICINE and are part of this report.

Some of these matters with which the Council has had to deal will be taken up seriatim and with the recommendations that the Council makes to this House of Delegates.

The Committee of Five.—The Committee of Five, created by the 1934 session of the House of Delegates at Riverside, is conducting a very comprehensive survey of the economic aspects of illness in California.

In coöperation with the California State Board of Health some $86,000 was secured from the SERA for field work and certain types of office work. The Council, in obedience to the resolution creating the Committee of Five, appropriated $32,750 for the work of the committee, necessary for the effective supervisorial investigative and skilled statistical work required for the proper conduct of the survey.

Preliminary and supplementary reports were submitted by the Advisory Economic Council and the Survey staff to the special session of the House of Delegates on March 2, 1935, at Los Angeles. At this session the Committee of Five also presented a majority report signed by four members, and a minority report signed by one member.

Because of delay, not within the control of the Council or the Committee of Five, the completion of the survey was not attained before the opening of the 1935 Legislature. After a joint meeting of the Senate Interim Committee, the Committee of Five and the Council on January 19 and further communication with the Senate Interim Committee, based upon discussions had at the aforesaid meeting, the Council called a special session of the House of Delegates to meet at Los Angeles on March 2 and 3, 1935.

The purpose of this meeting was to express an opinion upon health insurance in California, based upon the material then available from the survey and the report of the Committee of Five. The necessity for this expression was created by the fact that the Senate Interim Committee was required to make its report to the Senate and was anxious for such expression from the California Medical Association.

In order that a maximum representation of the component county societies might be had for the expression of the Association's attitude upon health in-

* The report of the Council was not printed in the "Pre-Convention Bulletin" of the April issue, in order that the status of legislative and other matters as of the date of the Yosemite annual session might be noted. The complete minutes of the House of Delegates will be printed in the July issue.

surance, the Council, following the lead of the American Medical Association at the special session of its House of Delegates in Chicago in February, 1935, defrayed the travel expenses of the delegates from the funds of the Association.

The action of the House of Delegates upon the majority and minority reports of the Committee of Five, which reports were published in the minutes of the meeting of the House of Delegates, is known to all and resulted in the creation by resolution of the Committee of Six, charged with the task of coöperating with the Senate Interim Committee and of safeguarding health insurance legislation according to the principles set forth in that resolution.

The report of that committee will be made by the committee to the House of Delegates.

Initiatives Nos. 9 and 17.—The chiropractors and naturopaths succeeded in placing upon the ballot, in November, 1934, two initiatives which would have given them almost unlimited rights in the practice of medicine in public institutions, etc. They brought every effort to bear to pass these.

It was only by the most intensive effort and the use of speakers, handbills, letters, radio and all obtainable newspaper publicity that the initiatives were decisively defeated at the polls.

The Council considered very deeply the import of these initiatives and concluded that every resource of the Association must be used for their defeat.

In pursuance of this purpose, $14,500 was expended for radio time and various types of literature for distribution. In this matter the Council received the valuable and effective coöperation of the Public Health League of California and expressed its thanks to that organization.

Other Legislation.—The subject of legislation at the 1935 Legislature will be covered in the report of the Committee on Public Policy and Legislation, Junius B. Harris, chairman. Other phases will be contained in the report of the General Counsel.

Legislation in Relation to Voluntary Health Insurance.—The Council believes that in looking to the future of medical practice in the State of California, the House of Delegates must consider the possibility that compulsory health insurance legislation may not be passed at the present session of the legislature.

The Council believes that the House of Delegates, at this session, should consider whether the Association should seek passage of a bill, by proper amendment, to provide a means whereby a voluntary system of health insurance might be instituted in California by component county societies or the California Medical Association if public demand render it desirable to do so.

In order to bring this matter before the House of Delegates for discussion, if it so desires, the Council presents the following resolution:

WHEREAS, At some later date, the California Medical Association or some of its component county societies may desire to develop plans for voluntary hospital or complete health insurance; and

WHEREAS, At the present time the laws of California make this development very difficult and at the same time provide no direct control of such practice; therefore be it

Resolved, That the Council of the California Medical Association is hereby instructed to secure, if possible, the passage of a bill providing, in the opinion of the Council, for the proper development and safeguard of voluntary health insurance plans in California.

Secretary-Treasurer.—On October 1, 1934, Dr. Frederick Cook Warnshuis assumed the office of secretary-treasurer, Dr. Emma W. Pope having resigned after eleven years of devoted and untiring service to the Association.

Dr. Benjamin Black of Oakland having been offered the position and because of good and sufficient reasons having had to decline it, it was found that Doctor Warnshuis, long-time secretary of the Michigan State Medical Society and Speaker of the House of Delegates of the American Medical Association, was available. After consideration, and in view of the mass of work confronting the office of the Association dealing with the approaching initiatives, health insurance, and other medico-economic problems, making a wide experience a very valuable asset to the Association, Doctor Warnshuis was offered the positions of secretary-treasurer and Director of Public Relations and accepted.

He has made numerous contacts with various component county societies and has carried the office of the Association through the busiest time of its existence smoothly and efficiently.

When the press of the legislation is done, he will visit all of the remaining county societies and their officers so that an invaluable personal contact will exist between the offices of the Association and all of its component county units.

Finances.—The expenditures of the Association this year have been unusual and large, and have cut deeply into its reserves.

While health insurance, the survey of the Committee of Five, and Initiatives No. 9 and No. 17 accounted for most of the expense, it is evident that the Association cannot continue on an unchecked course of expenditure such as has characterized the past year.

The Constitution and By-Laws protect the funds of the Association from undue expenditures upon the part of individual officers. The Council suggests that serious thought be given by the House of Delegates before any further expenditures, unknown in amount at the time, are authorized by the House of Delegates outside of the usual control provided by the Constitution and By-Laws and that the House go on record as supporting the Council in any future refusal to assume obligations of actions begun by members or component county units of the Association without consultation with or permission of the House of Delegates or the Council of the Association.

Needless to say, the Council considers the reëstablishment of the 1933 financial status of the Association funds of prime importance and calls the attention of the House of Delegates to the necessity of further calls upon the reserve funds of the Association now held by the Trustees Of The California Medical Association, a corporation, to defray expenses of the Association in 1935.

Budget.—The Council submits the following budget for the approval of the House of Delegates, it having been submitted by the Auditing Committee, approved by the Executive Committee and the Council:

BUDGET—1935-1936

Estimated Income:	
1. Membership dues—5,200	$52,000.00
2. Earned interest	100.00
3. Herzstein bequest	750.00
4. Advertising income	20,000.00
5. Commissions	500.00
6. California and Western Medicine subscriptions	500.00
7. Reprint sales	1,500.00
8. Sales of books	180.00
9. Estimated Income	$75,530.00
Estimated Expenses:	
10. Public Relations	$ 1,000.00
11. Postgraduate work	1,500.00
12. Legislative expense	4,400.00
13. Committee expense	1,000.00
14. Legal expenses	6,000.00
15. Fair exhibits	1,000.00
16. Annual meeting	1,000.00
17. Delegates, American Medical Association	1,500.00
18. Woman's Auxiliary	150.00
19. Council travel expense	750.00
20. Executive Committee travel expense	500.00
21. Printing California and Western Medicine	20,000.00
22. Editor's salary	4,000.00
23. Journal assistance	2,800.00
24. California and Western Medicine miscellaneous	500.00
25. Rent	3,500.00
26. Telegraph	300.00
27. Stationery supplies	1,000.00
28. Postage	750.00
29. Office supplies	250.00
30. Express and cartage	100.00
31. Stenographic services	6,000.00
32. Travel expense	1,200.00
33. Office files	250.00
34. Director Public Relations' salary	4,000.00
35. Secretary's salary	6,000.00
36. Publicity estimate	3,000.00
37. Reserve	6,080.00
38. Estimated expenses	$78,530.00

EXPLANATORY STATEMENT CONCERNING BUDGET

1. It is estimated that by a persistent campaign and individual correspondence we can bring membership up to the 60 per cent standard of the country.
2. Because of depleted reserve the interest earnings may not equal this amount.
4. There is good reason to believe that advertising income may be increased. Advertising is being resumed and now accounts are obtainable.
5. From the Coöperative Medical Advertising Bureau.
6. By eliminating certain exchanges subscriptions will be increased.
7. Earnings obtainable from Reprint sales.
9. Gross income of at least $75,530 is a reasonable estimate.
11. To cover expenses of Extension Lectures, Postgraduate Council District conferences.
12. Self-explanatory.
13. To cover printing and expenses of all Standing Committees.
14. Self-explanatory. May be less, if extra legal services are not required.
15. Equals expenditures of 1934.
16. Arbitrary amount. If the estimated sale of exhibit space is realized there will be a profit and not an expense for the annual meeting.
17. Increased because the American Medical Association meeting is in Atlantic City.
18. Auxiliary request.
19 and 20. These two amounts should cover travel expenses of Council meetings and monthly Executive Committee meetings.
21. Printing cost is on basis of 1934.
24. For feature issues and to cover binding, stationery, telegrams and similar editorial and business expenses and binding volumes.
25. Under terms of executed lease.
27. Stationery, membership certificates, county report blanks, envelopes, etc.
28. Includes all correspondence of all departments, mailing certificates and lay correspondence.
31. Present schedule.
32. Secretary's State travel to county societies, Council meetings, postgraduate conferences. Items to be approved as to amount in each instance by Auditing Committee.
33. It is purposed to build a Reference Library so as to have immediately available reference facts, thereby obviating writing to the American Medical Association and State organizations and delay while waiting for replies. Cost will be for files and reference indexes and classification.
36. This is an estimated reserve that will be increased in amount as savings are made in the appropriated items. The Association should plan to place about 10 per cent of its gross revenue into reserve and so rebuild its assets which have been expended this year in two major activities.

Note.—No expenditures will be incurred when the individual appropriations are expended. Additional expenditures must await action by the Council, upon recommendation of the Auditing Committee.

Dues.—The Council recommends to the House of Delegates that the dues for the year 1936 be set at the present amount of $10.

Legal Department.—The Council, by resolution on December 22, 1934, created a committee to survey the legal activities and expenditures of the Association for the preceding five years. This committee consisted of Doctors Roblee, Kiger and Gibbons, and after a thorough study it submitted the following report which, with its recommendations, is made a part of this report.

This report was printed in CALIFORNIA AND WESTERN MEDICINE, April, 1935, page 321.

Maternal Welfare.—The American Committee on Maternal Welfare, Incorporated, is an outgrowth of a Joint Committee on Maternal Welfare established many years ago by action of the American Child Health Association, asking coöperation of the American Gynecological Society, the American Association of Obstetricians and Gynecologists, and the Section on Obstetrics and Gynecology of the American Medical Association, in the formation of a joint committee to promote the cause of maternal welfare.

The organizations represented by the present American Committee on Maternal Welfare are:

American Association of Obstetricians, Gynecologists, and Abdominal Surgeons.
American Child Health Association.
American College of Surgeons.
American Gynecological Society.
Section on Obstetrics and Gynecology of the American Medical Association.
American Public Health Association.
Central Association of Obstetricians and Gynecologists.
Chicago Maternity Center.
Children's Bureau, Department of Labor.
Maternity Center Association of New York.
Pacific Coast Society of Obstetrics and Gynecology.
Southern Medical Association.

The major program of the committee now is to secure the formation of committees in all of the states for the furtherance of maternal welfare.

The American Committee has one of two plans in view:

First: The formation of a committee by each state society in the American Medical Association; and failing of this in any state, second, the appointment by the committee of members in a given state to form a committee to further the development of a maternal welfare program.

In the opinion of the Council, the first method is the desirable one because the development of a maternal welfare program will be in the hands of the California Medical Association, in coöperation with the American Committee on Maternal Welfare, instead of in the hands of a committee responsible only to a national organization other than the American Medical Association.

Unquestionably, the advancement of maternal welfare is a matter which can well receive the attention of the California Medical Association, and in furtherance of the plans proposed by the American Committee on Maternal Welfare the Council recommends the adoption by the House of Delegates of the following resolution:

WHEREAS, The American Committee on Maternal Welfare, composed of representatives from the various professional and social organizations in the United States interested in increasing maternal care and the reduction of maternal and infant mortality, has embarked upon an extensive program in the United States; and

WHEREAS, There can be no question that the work contemplated by this committee is desirable and, if effectively carried out, will result in great benefit to both the public and the profession; and

WHEREAS, In the opinion of this House of Delegates, the work can best be done in California by the coöperation of the California Medical Association with the American Committee on Maternal Welfare; therefore be it

Resolved, That a committee of five members of the California Medical Association from the section on Obstetrics and Gynecology be appointed by the Speaker, this committee to serve until the next annual session of the California Medical Association, to elect its own chairman and secretary, and to coöperate with the American Committee on Maternal Welfare in the development of a program for the advancement of maternal welfare in California; and be it further

Resolved, That such reasonable expense be allowed this committee as shall be authorized by the Council.

Charters.—This Council recommends that charters be issued to: The Sacramento Society for Medical Improvement, the Lassen-Plumas-Modoc County Medical Society, and to the Mendocino-Lake County Medical Society.

Respectfully submitted,

THE COUNCIL OF THE CALIFORNIA MEDICAL ASSOCIATION,

By T. Henshaw Kelly, *Chairman.*

COMPONENT COUNTY MEDICAL SOCIETIES

MONTEREY COUNTY

The regular meeting of the Monterey County Medical Society was held Friday evening, May 3, at the Hotel Del Monte. After the dinner a short business meeting was held in which SERA policies were discussed. The rest of the evening was left for the speaker of the evening, Dr. George Warren Pierce of San Francisco.

Doctor Pierce gave a very interesting and instructive talk on *Burns* and on the surgical repair following severe skin injuries. Lantern slides were used to good effect in illustration of this very fascinating subject.

WILLIAM H. LAWLER, *Secretary.*

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ORANGE COUNTY

A very lengthy meeting of the Orange County Medical Association was held at the usual time and place in the Orange County Hospital on May 7.

The new constitution was unanimously accepted and two amendments proposed, namely, the raising of the initiation fees from $2 to $10, and raising the local dues from $2 to $5.

The matter of paying city taxes was brought up, and it was felt that perhaps it was not quite just to have to pay a city tax as well as a State tax. The matter was referred to the Public Relations Committee.

Conforming to the new constitution, the election of an editor for the bulletin took place. Dr. Lawrence Cameron of Santa Ana was unanimously elected.

The first reading of the application of Dr. Thomas B. Rhone of Orange was read.

By ballot, Dr. H. Milton Counter of Buena Park was unanimously elected to membership.

Doctor Curtis reported that the Antivivisection Bill had been killed in committee.

There was some discussion on the Health Insurance Bill and considerable expression of opinion against it, as it apparently has gone through a number of changes.

Mr. Robert Speed, the manager of the newly formed Orange County Medical Bureau was present and spoke on the plans being rapidly formed and carried out for the desired functioning. This bureau is composed of the majority of the members of the Orange County Medical Association and, among other things, it will serve as a collection bureau, rating bureau, etc. Doctor Johnston of the committee read the Articles of Incorporation, and it was unanimously agreed that this corporation be formed as outlined in the Articles of Incorporation.

Llewellyn E. Wilson gave the scientific paper of the evening. His subject was *Report of the Orange County Hospital Poliomyelitis Epidemic in 1934.* Doctor Wilson is the medical resident physician of the Orange County Hospital. His talk was very interesting, and it would indicate that the 1934 epidemic was of new form or an evolution of this disease. Doctor Sutherland, the county health physician, remarked on the splendid work of Doctor Wilson and the hospital staff in this epidemic. A unanimous expression of appreciation was extended to Doctor Wilson and the hospital for his splendid work and self-sacrifice in the 1934 poliomyelitis epidemic.

WALDO S. WEHRLY, *Secretary.*

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PLACER COUNTY

A special meeting of the Placer County Medical Society was held at the Freeman Hotel, Auburn, on Saturday evening, May 4. The meeting was unique in the history of the Society in that it was not called by the secretary. The secretary, being unaware of the purpose of the meeting, was kidnapped and, by means of drugs and false promises, was taken by force to the Freeman Hotel where, upon his arrival, he found that a complimentary dinner in honor of his approaching elevation to the presidency of the California Medical Association had been prepared. There were present, on this delightful occasion, the following members and visitors:

Members—Dr. Louis E. Jones, president; Doctors C. E. Lewis, P. D. Barnes, Lucas W. Empey, Robert H. Eveleth, L. B. Barnes, J. Gordon Mackay, W. M. Miller, Max Dunievitz, W. A. Vinks, C. C. Briner, J. A. Russell, D. M. Kindopp, Ray C. Atkinson, and Robert A. Peers.

Visitors—Doctors F. F. Gundrum, A. M. Henderson, H. M. Kanner, F. P. Brendel, C. B. Jones, F. N. Scatena, Edward Babcock, Norris R. Jones, D. F. Dozier, all of Sacramento; Dr. Thomas C. O'Connor of Murphy, Dr. C. A. Wayland of San Jose, Dr. H. B. Trimble of Oakland, and Doctors E. H. Falconer and Sidney J. Shipman of San Francisco.

Dr. Max Dunievitz acted as toastmaster and master of ceremonies.

The banquet might well be described in the language of the immortal diarist, Samuel Pepys: "And after greeting them, and some time spent in talk, dinner was brought up, one dish after another, but a dish at a time, but all so good; but, above all things, the variety of wines (and excellent of their kind), I had for them, and all in so good order, that they were mightily pleased, and myself full of content at it; and indeed it was, of a dinner of about six or eight dishes, as noble as any man need to have, I think; at least, all was done in the noblest manner than ever I had any, and I have rarely seen in my life better anywhere else, even at the Court."

Between courses there were short talks by each of the members and visitors, in which many complimentary things were said regarding the guest of honor. In fact, they were so complimentary that the latter felt the speakers must have been thinking of "some other fellow."

Following the banquet the guest of honor was "booked and caned." The book was a beautifully bound copy of Dr. William Macmichael's "The Gold-Headed Cane," which was presented, on behalf of the group, by Dr. Ernest H. Falconer, who gave a short history of "The Gold-Headed Cane." Doctor Mackay then presented the secretary with a gold-headed cane, an exact replica of the one described in Doctor Macmichael's work, and carried by Radcliffe, Pitcairn, Baillie, Mead, and Askey.

At this point there was read a telegram of congratulations from Past Presidents Reinle, Hamlin and Harris, and Secretary F. C. Warnshuis, General Counsel Peart, and T. Henshaw Kelly. The tone of the telegram indicated very clearly that the boys were enjoying thoroughly their own Merritt Hospital picnic at Doctor Reinle's ranch at Calistoga, Napa County.

The meeting broke up in the early morning, with the secretary returning to his home feeling very happy.

ROBERT A. PEERS, *Secretary.*

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SACRAMENTO COUNTY

A regular meeting of the Sacramento Society for Medical Improvement was called to order by the president, Dr. Orrin S. Cook, on January 15, at 8:30 p. m. The meeting was held at the Elks Temple. Sixty-three members and guests were present.

The paper for the evening, *Trends in Modern Medicine,* was delivered by Dr. Frederick C. Warnshuis, secretary-treasurer of the California Medical Association. The paper included an interesting discussion on the present status of social medicine and what is expected in its development in the immediate future.

Appreciation of the paper was voiced by Doctors Edward Babcock, Henderson, Becker, Saeltzer, C. B. Jones, Dozier, and Cook.

The secretary read the board of directors' report and introduced the new president for 1935, Dr. Orrin S. Cook.

Doctor Cook announced the committees to serve during 1935:

Publicity Committee—Doctors Dozier, O. F. Johnson, and Phillips.

Program Committee—Doctors Ankele, Becker, and Ruddy.

Banquet Committee—Doctors Norris Jones, Iki, and Schluter.

Public Relations Committee—Doctors Wallerius, Christman, Burden, Lawson, and Kanner.

Communications were read. The matter of malpractice insurance was discussed, and it was suggested

by Doctor Schoff that the matter be referred to the attorney of the California Medical Association.

Doctor Scatena reported for the Constitution Committee.

Doctor Babcock gave a short talk on the activities of the Sacramento Tuberculosis Association. It was moved and seconded that the Public Relations Committee confer with Mr. Johnson of the Tuberculosis Association. Motion passed.

Doctor Soutar gave a report on the legal requirements of physical education in the public schools and asked for closer coöperation by physicians in regard to allowing excuses from physical education classes.

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A regular meeting of the Sacramento Society for Medical Improvement was called to order by the president, Orrin S. Cook, at 8:30 p. m. on February 19 in the Elks Temple. Seventy-five members and guests were present.

Mr. Harold McCurry of the Sacramento Chamber of Commerce gave a ten-minute talk, outlining the plans which the Chamber has for the future and requesting the coöperation of the medical society.

The paper of the evening was given by Dr. William Dock, associate professor of medicine at Stanford University Medical School. He gave an interesting and instructive talk on ***Heart Disease Beginning in Patients Late in Life.*** He spoke of the involutionary changes taking place in the arteries and muscles of the heart of an elderly person and compared them with the graying of the hair. The treatment of these diseases of the heart was outlined. The paper was illustrated by case reports and lantern slides.

The paper was discussed by Doctors O. F. Johnson, Gundrum, and Reardan.

The application of Dr. Francis J. Cox was read for the first time. The application of Dr. Loris E. Curtis was read for the second time and voted upon. Doctor Curtis was unanimously elected to membership in the Sacramento Society for Medical Improvement.

FRANK WARNE LEE, *Secretary.*

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SAN JOAQUIN COUNTY

The regular monthly meeting of the San Joaquin County Medical Society was held in the Medico-Dental clubroom on May 2. The meeting was called to order at 8:15 p. m. by President C. A. Broaddus.

A supper meeting was held at the Hotel Clark at 6:15 p. m. at which there were twenty-six present, including two guests. The papers of the evening were presented by Doctors Collis, Rosasco, and D. Powell. Doctor Powell spoke on the present status of the ***Social Security Insurance Bill.***

The minutes of the preceding meeting and of a meeting of the board of directors were read and approved.

The application of Dr. Martin Karr of Sonora for membership was read and referred to the Membership Committee.

Doctor Sheldon reported on the communication from the Stanislaus County Medical Society relative to the x-ray fee schedule.

Doctor Kaplan submitted the report for the Committee on the SERA.

Doctor Broaddus reported on an organization meeting of the Ethics Committee, which was held at a supper meeting at Doctor Barnes' residence, and announced that Doctor Kaplan had been appointed chairman for that committee.

Doctor McGurk announced that the family of our deceased member, Dr. L. R. Johnson, was unveiling a memorial plaque on May 26 at 2 p. m., in the Sierra, three-fourths of a mile from the Big Trees Hotel.

Doctors Karr, Rosasco, and Stewart were introduced from the floor.

The first scientific paper of the evening was given by Dr. Daniel G. Morton on ***Toxemias of Pregnancy.*** He spoke on the importance of the early recognition of those conditions and emphasized that the weighing of the patient, blood pressure determinations, and urine examinations should be done routinely and frequently. He also touched on their treatments. The second paper was given by Dr. J. L. Carr. His subject was ***Pathologic Lesions Caused by Toxemias of Pregnancy.***

The papers were discussed by Doctors S. Sanson, P. B. Gallegos, M. Goodman, L. Collis, F. Doughty, D. G. Morton, and J. L. Carr.

President Broaddus then announced that the June meeting would be held at the new Basque Hotel.

There being no further business to come before the Society, the meeting was adjourned at 10:12 p. m. and refreshments were served.

G. H. ROHRBACHER, *Secretary.*

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SANTA BARBARA COUNTY

The regular meeting of the Santa Barbara County Medical Society was held in the Bissell Auditorium of the Cottage Hospital on Monday evening, May 13, Vice-president Gray calling the meeting to order.

The speaker of the evening was Dr. A. C. Reed, professor of tropical medicine, University of California. He gave an extremely interesting and instructive talk on ***Amebiasis,*** covering the diagnosis and treatment, with particular stress on the importance of efficient public health measures. He also touched lightly on several of the other tropical diseases that would probably soon be found in California. The paper was discussed by Doctors Freidell, Roome, and Preuss.

Following this a film showing the development of ***malaria*** was shown.

The Society then went into executive session, and the minutes of the previous meeting were read and approved.

Doctor Steele reported for the Tuberculosis Committee, and it was moved, seconded and carried, that the secretary invite Mr. Higbee, secretary of the California Tuberculosis Association, and Miss Carlson, field worker, to come to Santa Barbara to assist in the organization of a Santa Barbara County Tuberculosis Association.

The secretary made a report on the questionnaires returned by the doctors, and it was moved by Doctor Stevens, and seconded, that a committee of five be appointed to segregate the various opinions expressed in the questionnaires and report back to the Society. An amendment to the motion was then moved, and seconded, that Doctor Stevens be a member of this committee. Carried. The original motion was put and also carried.

WILLIAM H. EATON, *Secretary.*

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SISKIYOU COUNTY

The last meeting of this Society was held at the Yreka Inn on Sunday, April 28. The committee to consult with the local SERA head was appointed, consisting of Doctors V. Hart, A. H. Newton, and Campbell.

A resolution was passed to wire State Senators McGuinness and Dan Williams and Assemblyman Fulcher that Siskiyou County Medical Society unanimously approves Senate Bill 454. Members were cautioned to pay no attention to the postals sent out by the State Chamber of Commerce.

Dr. C. C. Dickinson and Dr. Victor Hart, delegate and alternate to the State convention, were instructed to oppose the reduction of fees by the State Compensation Insurance Fund.

Doctor Newton read a paper, ***A Case of Gas Bacillus Endometritis and Its Successful Treatment.*** This was enjoyed by the Society and the members of the newly formed Auxiliary.

The next meeting will be held in McCloud on May 26.

LESLIE J. SEELEY, *Secretary.*

SONOMA COUNTY

The Sonoma County Medical Society held its regular meeting on May 9 at the Sonoma State Home. Forty-five members and guests were present.

Dr. F. O. Butler, medical director of the State Home and president of the County Medical Society, was host, and entertained the members and guests of the Society in his usual gracious manner.

Following a marvelous repast, the regular meeting of the Society was held in the institution's auditorium. After transacting routine business and receiving three new applications for membership, Dr. S. H. Fredrickson, anesthetist for the Home, presented a paper upon *Spinal Anesthesia,* she having administered, during the past two years, over seven hundred such anesthetics with very satisfactory results.

The meeting was well attended, the program enthusiastically received, and all went home feeling that the evening was well spent.

W. C. Shipley, *Secretary.*

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TULARE COUNTY

The regular monthly meeting of the Tulare County Medical Society was held at Motley's Café in Visalia on Sunday, April 28, at 6:30 p. m. The Dental Society of Tulare-Kings County met with us as guests of the Society. Dinner preceded the meeting.

Dr. Ray Rosson presided at the meeting and welcomed our guests. The minutes of previous meetings were read and summarized with regard to the activities of the Committee on Hospitals. The Tulare County Board of Supervisors entertained the findings of the committee as submitted in the last minutes on April 16, and after a brief discussion voted three to two against the plan. Mr. Patterson and Mr. Allenbaugh were in favor of the proposed plan, and Messrs. Elliott, Armstrong, and Oliver, against it.

The pamphlet on the Health Service Insurance Act was referred to the Public Relations Committee for a report.

Doctor Rosson read an invitation from County Dairy Inspector Howard Smith to visit the laboratory at Tulare.

Dr. John S. Glenn was elected to membership in the Society, and Dr. J. Tracy Melvin's name was proposed for retired membership.

The subject of placing professional cards in the local newspapers, under a Society membership listing, was referred to the Committee on Public Relations for an opinion.

A letter from the SERA Administration was read and a committee is to be appointed to take care of this matter.

Doctor Furness proposed, and the motion was seconded and carried, that a uniform fee system be established for examination in cases of "drunk while driving": Examinations, $5; appearance in Justice Court, $5; appearance in Superior Court, $10.

Notice of this adopted schedule is to be sent to all members and to Attorney McCormick.

At the conclusion of the business session the meeting was turned over to the program for the evening. Dr. John Lloyd of Lindsay, president of the Tulare-Kings County Dental Society, responded for the dentists.

The guest speaker for the evening was then introduced by Dr. W. W. Cross of Oakland. A former Visalia practitioner, A. E. Sykes, D. D. S., of Oakland, member of the Academy of Periodontology, presented a splendid paper on *Dental Radiographic Interpretations.* Lantern slides were used in illustration. The subject dealt chiefly with calcium and phosphorus metabolism and the endocrine aspect of the findings as interpreted from x-ray studies, and opens a very important consideration in coöperative dental and medical attention to the patient. In conclusion, Doctor Cross spoke briefly on the *Endocrinologic Relationships.* General discussion and questions followed the paper, and a rising vote of appreciation was extended Doctors Sykes and Cross.

Karl F. Weiss, *Secretary.*

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YOLO-COLUSA-GLENN COUNTY

The Yolo-Colusa-Glenn County Medical Society met in regular session at the Hotel Riverside in Colusa on April 24.

After the dinner the following business was transacted. A motion was made by Doctor Woolsey that a protest be made to the Industrial Accident Commission against the change in the fee schedule. This motion was carried, and Doctors Woolsey and Nichols were appointed to draw up and send such resolutions to the Industrial Accident Commission.

The SERA relief program was discussed, and Dr. Fred Fairchilds of Woodland, Doctor Walker of Willows, and Doctors Keith and Rathbun of Colusa were appointed to contact the Relief Administration officials of their respective counties and perfect a local medical relief program.

The secretary was instructed to write the State SERA, giving the names of these committee chairmen.

Dr. Edwin I. Bartlett of San Francisco gave a very interesting lecture, illustrated by slides, on *Tumors of the Breast,* giving the physiology, various types of pathology, and then giving, in a general way, the surgical treatment of these conditions.

The meeting was adjourned to meet in Willows in June.

Ray E. Nichols, *Secretary.*

CHANGES IN MEMBERSHIP

New Members (47)

Fresno County.—Klenner F. Sharp.

Los Angeles County—

Samuel K. Bacon
Irving E. Benveniste
Lewis P. Bolander
James E. Burns
R. J. Cary
Carl F. Doehring
Nona Gilbert
W. Ray Henderson
Dorothy Hewitt
Harry H. Jacob
Carvel James
Arthur R. Jewell
Paul B. Kinney
Herman Lando
H. Ross Magee
C. W. Reeder
Joseph Rosenblatt
Hilliard E. Smallberg
Paul T. Southgate
Maxwell J. Wolff
W. W. Woods
F. B. Zombro

Orange County.—H. Milton Counter.

Riverside County.—Fred A. Clark, James B. Oliver.

San Bernardino County.—Darnell E. Hayhurst, Joseph S. Hayhurst.

San Diego County.—Howard A. Ball, J. B. Eneboe, Milo B. Fuller, Homer D. Hoskins, J. B. McConnell.

San Francisco County.—Donald G. Davy, Joel H. Hanson, Ernest William Henderson, Robert E. Hughes, Donald Eliot King, Paul D. Michelson, Isabelle H. Perry, Victor E. Putnam, James Francis Shea, Lloyd B. Shone, Harold G. Watson.

Santa Clara.—Anthony J. Monty.

Tulare County.—William A. Winn.

Yuba-Sutter County.—Philip Edward Thunen.

Transferred (5)

Marcel R. Bedri, from Monterey County to Los Angeles County.

Bertrand S. Frohman, from San Francisco County to Los Angeles County.

Jack C. Hill, from Imperial County to Riverside County.

Henry Hoagland, from Los Angeles County to Riverside County.

John A. Pearson, from Los Angeles County to Montana.

In Memoriam

Hatch, Willis Grant. Died at Santa Cruz, April 16, 1935, age 66. Graduate of Rush Medical College, Chicago, 1897. Licensed in California in 1921. Doctor Hatch was a retired member of the Santa Cruz County Medical Society, the California Medical Association, and the American Medical Association.

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Kapp, Russell William. Died at San Jose, May 5, 1935, age 36. Graduate of Hahnemann Medical College of Philadelphia, 1925, and licensed in California the same year. Doctor Kapp was a member of the Santa Clara County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION*

MRS. THOMAS J. CLARK ..... President
MRS. ELMER BELT ..... Editor and Chairman of Publicity

State Auxiliary News

REPORT OF THE PRESIDENT—FOR YEAR 1934-1935

My dear Coworkers:

It is with a feeling of sincere humility that I write my swan song as President of the Woman's Auxiliary to the California Medical Association.

A group of exceptionally loyal and untiring presidents have left records of marked achievements. The work done under their leadership has been so far-reaching and successful that this office carried with it a challenge of accomplishment.

When I assumed my duties last May I fully realized the earnest effort that must be put forth to make this year under my administration measure up to the standards of other years.

I could not have begun my work if I had not had the confident expectation of the coöperation of our entire membership—and in this I have not been disappointed. Whatever of real achievement has been ours this year is due in large measure to this cooperation.

We have grown to a point where we are no longer a group of a few workers, but an organization that stands out as an example of what enthusiasm and united effort can accomplish.

In reviewing the work of the past year, it shall be my endeavor to summarize our activities, mindful that each standing committee chairman will develop for you the work of her department and each county president will herself record the achievements of her own group. I ask for your full attention to the reports when read, as they will bring to you in clear, concise detail whatever of accomplishment has been ours. In digressing from the usual precedent of incorporating in this report of mine the activities of the various committees and counties, I have but one thought in mind—to give each one of them the full credit that is rightfully theirs, of passing on to you first hand the records of their endeavors and achievements. Furthermore, at the proper time, opportunity will be given for recommendations and your consideration of plans for future work.

In recording the highlights of the year, I am reminded of the encouragement that was mine when, in late May, a splendid group of women under the leadership of Mrs. N. N. Brown organized an Auxiliary in Kern County. I regarded this new unit as a happy augury in the beginning of the year.

Some days later I left to attend the national convention in Cleveland. The memory of that visit still lingers as perhaps the most enlightening and stimulating experience of the year. From the rather exhaustive report made after my return, you may have gathered that my reactions indicate it is not only desirable but almost imperative that an incoming state president should have the privilege of attending the national meeting which closely follows our own annual session. The contacts with national officers and other state presidents are invaluable, and at once inject the personal equation into the national perspective. In my case it vitalized my viewpoint and gave me added assurance that California was and is a necessary cog in the big national wheel.

On my return from Cleveland the good news reached me that Mrs. Sargent had effected the organization of an auxiliary in Santa Clara County. A splendid group now numbering seventy-eight members. Mrs. Sargent may well be proud of this baby of hers. We all look for great things from Santa Clara, which at this time is the sole unit representing the fifth district.

Contacts have, perhaps, been our most tangible assets. It was our good fortune to be invited and to have served as hostesses for the annual convention of the American Public Health Association in Pasadena, in September. Many members of the State Board and representative women from near-by counties gave generously of their time and effort and I may add, during unprecedented heat, to make this occasion both successful and memorable. Considerable time was given to the detailed preparation of our program during the summer. In this I was most fortunate in having as co-chairman, Miss Florence Burger of Pasadena, with whom I have been associated in civic work over a period of years. While not a member of the Auxiliary nor even remotely eligible, she possesses a medical consciousness that prompts sustained interest and activity in our field. I should like to record the appreciation of our organization for her service last fall. That the part played by the Auxiliary was a definite contribution to the American Public Health Association is best evidenced by the resolution of appreciation received from the Association some days later.

In November I made a trip to San Francisco to confer with Doctor Warnshuis, secretary of the California Medical Association. We are most fortunate to have so staunch and understanding a friend in the State official family. He was most gracious, interested in our problems, and offered his support and coöperation. You may recall that Doctor Warnshuis as Speaker of the House of Delegates of the American Medical Association presided over that group when, in 1922, Texas presented the resolution to form the National Woman's Auxiliary.

The matter of much needed additional space in CALIFORNIA AND WESTERN MEDICINE was taken up at Mrs. Belt's request by Mrs. Scatena and myself during our visit to San Francisco. Mrs. Belt made the request to Doctor Kress, who replied that this was a matter for the Council to determine. Mrs. Scatena and I then called upon Dr. T. Henshaw Kelly, chairman of the Council. He expressed his appreciation of the excellent work of our editor and indicated that when the matter would be presented to the Council, it would receive his approval. Subsequently, our request was granted and two full pages are allocated for our use in each issue. Space in this JOURNAL is at a premium and we are most appreciative of their generosity. Our editor now has an opportunity to present items of national and State interest as well as the reports of our county meetings. Mrs. Belt, duly authorized by the

* As county auxiliaries to the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Elmer Belt, chairman of the Publicity and Publications Committee, 2200 Live Oak Drive, Los Angeles. Brief reports of county auxiliary meetings will be welcomed by Mrs. Belt and must be sent to her before publication takes place in this column. For lists of state and county officers, see advertising page 6. The Council of the California Medical Association has instructed the editor to allocate two pages in every issue for Woman's Auxiliary notes.

State Board, prepared and presented in December the initial number of our State news-sheet, the *Courier*. To Mrs. Belt I give the fullest measure of praise and appreciation for this very creditable endeavor. She has brought to us and to our state organization by her own initiative and able execution a new and lasting thought of great inspirational value. Perhaps I may be pardoned at this point, a fitting tribute to her—an excerpt from a quotation recently sent me by Mrs. Chester Teass of San Luis Obispo. "A great deal of joy of life consists in doing perfectly, or at least to the best of one's ability, everything which one attempts to do. It is this conscientious completeness which turns work into art. The smallest thing well done, becomes artistic." The lines may be from William Mathews, but the thought that inspired them might well have been my own, as expressing with fidelity, the character of everything that Mary Ruth Belt undertakes.

The second edition of the *Courier* has recently appeared and gives added promise of fulfilling even to a larger degree the purpose for which it was designed. I hope that our little paper has earned for itself a permanent place in your Auxiliary heart.

At the board meeting in September, a resolution was adopted suggesting the advisability of making each county year correspond with the state year, and to that end we asked that the annual meetings of counties take place in May or June. The advantage of this procedure is obvious. It is gratifying to know that the majority of counties have responded favorably. This change will make for a better synchronization of work between county and state, and afford each county president the opportunity of making her full year's report at the annual convention.

Medicine is largely controlled by non-medical factors—harmful legislation and insidious propaganda by persons ignorant of the status and possibilities of medical science. Scientific medicine has advanced to a place of value never approached heretofore, yet it is not held in the esteem it deserves, or even that which was accorded it years ago. Thus we have the paradox of the greatest of all professions advancing in efficiency but declining in so-called popularity. It is, therefore, one of the prerogatives of every member of the Auxiliary—a definite duty—to aid in preventing and correcting adverse criticism. Through sustained public health education we can do much. We should be, as doctors' wives, the liaison between the profession and the lay public, strive at every turn to make the status of the medical man clear, to promote a better understanding of the problems that confront the profession at this time. As an example of what value we may be, let me refer to the call to arms early last autumn, when we were asked to marshal our forces in an attempt to defeat two insidious measures that were on the State ballot, initiatives number nine and seventeen. Much credit—well earned—is given the women of the Auxiliary by the California Medical Association, the Public Health League of California and many county medical units, for the outstanding service rendered which resulted in the defeat of the Naturopathic and Chiropractic measures at the fall election.

There is every reason to believe that the increase in our membership is indicative of, first, a normal, natural growth; second, a keener interest, perhaps, by some who have been sitting on the side lines waiting to see if the objectives and ideals of our organization synchronize with their own before they would join our group, and, third, the sustained activity of the membership committees throughout the State to bring into our Auxiliary those women who, through no fault of their own, were unmindful of the opportunities of service to the cause of scientific medicine which it is our devout wish to offer. One of our national past presidents is quoted as saying, "A good healthy report on organization and membership shows that a State is in a healthy condition." Perhaps this year the California climate will receive all the credit!

To Mrs. William H. Sargent I wish to express particular gratitude for her work as chairman of the committee on membership and organization. She has carried our message into many counties, and has the promise of additional organized units this coming year. I believe her efforts are of inestimable value. She has the Auxiliary in her blood stream and is equipped with unusual ability to "sell" the Auxiliary idea. It is heartening to consider the unselfishness of Mrs. Sargent in her willingness to continue her invaluable service on the board after years in executive positions. I salute her fine spirit and her achievements, and am grateful.

Our Public Relations Committee has presented an outstanding program this year, and has been entirely successful in the consummation of plans for increased activity in every county. The field is a large one and an open one. The very nature of the work demands as a leader, a woman of vision, initiative and ability, who recognizes the resources of a few and the limitations of many county units, and who will not demand or expect the impossible from any. Mrs. Barrow has carried on in a superlative manner, injecting into her work the enthusiasm and optimism for which she is known to be richly endowed. I believe that this year will show better results because of the coöperation she has had from the county public relations chairmen, which is a necessary factor in the correlation of a program of such vast possibilities. Mrs. Barrow has laid the foundation for great work in this field and has intelligently interpreted the need of our sustained interest in an active contact with other organized groups. In thanking Mrs. Barrow for her endeavors I am only voicing the appreciation of every member of the Auxiliary.

There is noticeable a splendid spirit of coöperation and an increased interest in health education matters, as is evidenced by the added number of requests that have come to us for information as to the subject matter for health programs in the schools, women's and civic organizations. I am happy to say that a "Health Institute" is to be incorporated in the fall program of one of our southern counties, San Diego, and another in the north, Alameda. The idea, sponsored by Philadelphia, should prove of great value, and it is my hope that it will find a definite and permanent place on the annual calendar of many counties in the near future. I thank Mrs. Howard for her part in this work.

Mrs. Sutherland has inspired greater efforts in all matters concerned with public health activities and has by her contacts strengthened our position, and stressed the need for closer relationship with those organizations which share with us a common interest.

We are deeply indebted to Mrs. Baxter and the members of her committee for increased interest in *Hygeia*. Their reports are most gratifying, showing that California's quota has been exceeded this year. However, we do not feel that the official health magazine of the American Medical Association has received the recognition it deserves. How best to stimulate interest and increase subscriptions still remains a problem. With a membership as large as ours, surely it is not too much to expect an average of one subscription to each member, or perhaps ask each member to be responsible for one subscription. The members of the *Hygeia* Committee have worked diligently and intelligently and are deserving of immeasurable praise for their sincere efforts.

We have been particularly fortunate in our recording secretary, Mrs. Henderson. Her work has been carried on with meticulous care, and into every detail she has fused a charm that has come to her through the gentleness of her personality and the understanding of doing her work well.

Correspondence of the year has, perhaps, made the greatest demands on many of us. A large portion has fallen to the lot of Mrs. Spiers, who has carried on with a smile and with her usual efficiency. I knew full well when she accepted my one and only appointment last May, that she would contribute much comfort to me personally, and leave a creditable record of service to the State organization. I can assure you that both contracts have been graciously carried out.

Our finances have been in the safekeeping of our esteemed treasurer, Mrs. Scatena, for the second year. With increased membership, her work has increased, and by the same token, we trust our balance may have taken on added weight. Mrs. Scatena's report will give you the story in her own word figures. I cannot emphasize enough the importance of her responsibilities or the value of her contribution to the Auxiliary, which we all acknowledge with affectionate appreciation.

Our historian this year, Mrs. Coulter, will present her story in a new garb. Until recently we have had a combination scrapbook and history. Frankly, in our opinion, these two records are deserving of separate settings. The history belongs to the historian and should be preserved with dignity and fidelity; the scrapbook belongs under the jurisdiction of the chairman of publicity, and should give evidence of the contribution of the press, both newspaper and magazine, of State Auxiliary activities, notices of meetings, convention data and other items of interest as the name of the book would imply. The scrapbook is at the moment in a state of transition, but when it appears next year at the convention, you may look for something creditable, the result of Mrs. Belt's labor of love.

Our State Board meetings have been well attended and at no time have we lacked a full quorum. Many county presidents have attended and expressed their pleasure in being included, and of having an opportunity to discuss county problems. An interchange of ideas is often valuable and still more often, quite desirable, and of mutual interest. My confrères on the State Board have carried the major portion of the burden of the work this year. Each officer has responded in a most gratifying manner to any request of mine for advice or assistance. My task has been a pleasant one, made so by the graciousness and kindness of my associates.

Six years have passed since the Auxiliary was organized. To me it seemed fitting that some recognition should be made of the work of those members who have contributed to our upbuilding, and who are no longer with us. Mrs. Percy in her "In Memoriam" today has inaugurated a memorial service which I believe should find a permanent place each year on our program.

The early spring of this year brought me a truly great moment, when a telegram came announcing the reorganization of San Luis Obispo Auxiliary. We all rejoice and welcome this splendid group back to the fold after a period of rest. For me, this action of theirs is a crowning tribute to the loyalty of old friends who have served well, and who by their renewed activity will reflect the importance of united effort in our organization.

Through the coöperation of the presidents of our southern counties, we have been able to respond to the request of the officers of the Southern California Medical Association for assistance at their recent session at Arrowhead Springs. The women from San Bernardino, close at hand, were called upon to assist in the various activities offered on the program. It is my pleasure to report that through Mrs. Arthur Walker and Doctor Roblee, a reorganization of the Auxiliary in San Bernardino is assured.

I wish to extend to Dr. William W. Roblee, chairman of our Advisory Council, my sincere appreciation for his coöperation at all times. He has been most generous in the time he has given me for conferences, has assisted our cause by making addresses to stimulate activity in unorganized counties, and in every way has contributed of his time and thought in the interests of the Auxiliary.

We are indebted to Dr. George H. Kress, editor of CALIFORNIA AND WESTERN MEDICINE, for many courtesies.

I wish to refer with deep appreciation to the hospitality that has been accorded me during the year by many county groups. I have enjoyed these meetings and am grateful for the joyous contacts on each and every occasion. Were it not for the physical limitations, I would have been able to visit every county, and deeply regret my inability to accept the courtesies extended to me by Santa Barbara, San Luis Obispo and Sacramento to meet with their groups in March and April.

I cannot bring this summary to a close without expressing a word of appreciation to our national president, Mrs. Tomlinson. While the distance of the entire continent separates us, she has been good enough to make us feel a real sense of nearness in her letters, and in her sustained interest and concern in all matters affecting California.

To Mrs. Clarke, who will so soon follow me, I bequeath the fulness of joy that has been mine in serving you, and added assurances of our loyalty and coöperation. May she, too, find a great content in the benediction of abiding friendships.

To you, each one, I say "Thank you."

HELEN STEWART DOANE.

* * *

IN MEMORIAM

By Mrs. James Fulton Percy

On this, the occasion of the sixth annual meeting of the California State Auxiliary, it is appropriate that we should take notice of the workers among our members who have passed on and who, in the previous years, have added so much to the stability and purposes of this organization.

Our president, Mrs. Doane, in inaugurating this memorial service, has, with especial insight, consummated the unexpressed wish in our hearts that those of us who are still permitted to carry on, might pause for a moment and recall the worth and works of the departed for the general upbuilding of the Auxiliary.

Our first thought is that they were doctors' wives and, therefore, had learned to share with their husbands the sympathy, understanding and wider vision that is the progressive endeavor of every physician in his humanitarian work. In the memory of great, human, loving kindness, there exists the seed of an imperishable joy which proves itself a sufficient foundation for man's faith.

Life has a strange and mysterious way of deciding for us when the day's work is done, and records such as are left by these friends and members are an inspiration to those who come after to do their share for the common weal. The Prophet has said, "The days of human existence are as vanishing shadows." "Our life is scarce the twinkle of a star, in God's eternal day."

The foundations of life are still far beyond the reach of investigation but among its realities as we perceive it, is the sense of trust in continual goodness and abiding love.

In the majestic grandeur of this wonderful valley, with the mighty sequoias that have flourished while countless civilizations have come and gone, the aisles of the sounding pines, its silences and shadows and the whisperings of peace, its suggestion of every kind of abundance, replica of life itself, we dedicate this service of loving remembrance, not only to our own dear members gone but as well to those faithful husbands who also, though lost to sight, to memory are ever dear. So unto our beloved dead, who are not dead, belong the homages of song, for from their lives we draw anew our dream of immortality.

As we bow our heads during the reading of the names of these friends, who during the past year have answered the final summons, there must come to us, deep in our hearts, promptings to fresh endeavor, to renewal of inspiration to carry us on to wider prospects, that continued hope may come with the south wind and courage with the sunrise.

Alameda County—Mrs. O. D. Hamlin and Miss Anna D. Kohlmoos.

Contra Costa County—Mrs. C. L. Abbott.

Los Angeles County—Mrs. John R. Haynes.

Orange County—Mrs. H. W. Robertson.

Riverside County—Mrs. Arthur W. Miller.

Sacramento County—Mrs. Burt F. Howard.

San Diego County—Mrs. W. S. McCauslane.

NEVADA STATE MEDICAL ASSOCIATION

COMPONENT COUNTY MEDICAL SOCIETIES

WASHOE COUNTY

The regular monthly meeting of the Washoe County Medical Society was held on the evening of May 14 in the State Building, Reno, Dr. M. A. Robinson presiding.

There was very little business to bring before the Society, except a resolution by Mrs. Alexander of Washington, D. C., who is on the national committee for federal legislation for birth control. Mrs. Alexander read a copy of the resolution with reference to birth control, such as was adopted by the national committee, and asked the Society to endorse it and send such endorsement to headquarters. The resolution was discussed pro and con, and the secretary was directed to correspond with the legal department of the American Medical Association to ascertain their opinion with reference to the same and report at the next regular meeting of the Society.

A resolution was read by the secretary, in substance directing the attention of the Society to the advisability of participating by prize donations or of helps to the students of the University of Nevada, especially those in the pre-medical department. The importance of the action suggested that the resolution be continued until the next meeting for final action.

There being no further business, the paper for the evening by Dr. John A. Fuller was called for. The subject of Doctor Fuller's paper was *Suppuration of the Middle Ear.* In substance, he said about as follows:

Probably no pathological condition causes more suffering and economic disaster than suppuration of the middle ear. It is estimated there are one million persons in the United States who are direct or remote sufferers from this affliction. The importance of this disease is that the general practitioner is the one who sees it first, and in many instances the treatment is of such temporary nature that before seen by a specialist damage to the middle ear and its structures is well under way. . . . It is readily seen that inflammation of this canal leads to swelling and occlusion of the tube, with the result that the tympanum becomes a walled-off cavity. This is exactly what happens in most cases of middle-ear infections. Pus sooner or later forms, and in expanding it follows the line of least resistance, with the result that the ear drum is ruptured. But in some instances the pus backs up through the additus, to the mastoid antrum, and then the patient has mastoiditis. It is true that not all cases go on to suppuration because, drainage being restored, pressure is removed and recovery follows.

A large majority of middle-ear infections originate in the nasopharynx; therefore the nose and throat should be inspected as being the principal etiologic factor. . . .

Symptoms were described, first, as a feeling of uneasiness, followed by lancinating pain. Fever and leukocytosis appear. Examination of the ear drum is imperative. This should be followed promptly by early drainage, if not by incision; then by such method or means as will cause shrinking of the nasal mucosa, thereby opening up the tubal orifice and restoring drainage.

The patient should be put to bed. The room should be warm and the usual treatment for any acute illness should be initiated. If seen early, in addition to the foregoing treatment, packing the entire external canal from the meatus to the drum lightly but firmly with plain cotton. This procedure immobilizes the drum head and equalizes the pressure from within, and usually relieves the pain almost instantly. If not quickly relieved, hot moist compresses to the side of the head and lower part of the neck hasten dilation of the blood vessels and assists absorption. Doctor Fuller expressed his opinion positively as against the usual treatment by the use of ear drops, as such clog up the external canal and obstruct visualization of the drum. If after a few hours these measures are not successful, or should the drum show distinct bulging, then a paracentesis under general anesthesia is done, and this is followed by hot compresses. Infected tonsils and adenoids should be removed if the suppuration tends to become chronic.

When treated by empiric measures the tendency is for the patient to develop a chronic otitis media. This is one of the most distressing of all human maladies. The suffering is not only physical, but mental. The patient with this affliction is in the million class. The small child in school is considered dull because he is not able to comprehend what is said to him, and as he grows into adult life, deafness, which has a tendency to increase in intensity as the patient becomes older, frequently bars the individual from many of the avocations of life. The earnest intent of the physician should be when he encounters a case of otitis media to immediately call in competent surgical help to forestall a condition which, if allowed to continue, may cause death through its many possible complications, or at best leave the individual crippled for life by defective hearing. THOMAS W. BATH, *Secretary.*

Essay on Recovery of Medical Prosperity.—The *Japanese Medical Journal* offered a prize for an essay on "How to Tide Over the Present Difficult Situation in the Medical Profession." In a six months' period eighty-three essays were received, most of them written by practitioners. The winners were recently made known. Dr. K. Nakadate won the first prize, 500 yen. In his essay he said that the causes of the present difficulties are, first, the surplus of physicians, which must be corrected by changing the system of medical education so as to divide the specialists and the general practitioners. The last two years in the medical college should be devoted to specialized education and the previous years to general education. A certificate for practice should be given after two years' practical training in approved hospitals after the student has finished the college courses. In the second place, any treatment done by those who are not physicians but are now sanctioned by the local governments should be entirely prohibited except when the practitioner recommends that they treat a patient under his personal guidance. Third, any health benefit associations organized under the pretext of lower medical fees should be dissolved, as they tend to commercialize the profession and prevent patients from exercising a free choice of physician. Fourth, the indiscriminate manufacturing of new medicines should be ended by careful regulation. The doctor with little experience is more apt to administer expensive new medicines and this is one reason for the high cost of medical care. The selling of medicine by practitioners has caused many complaints, and the lower classes are inclined to refrain from consulting the doctor lest they be obliged to pay too much. This is an essential cause of the present trouble, to say nothing of the general business depression. Fifth, medical advertisements, especially on the roadsides or in the stations or on roofs, should be utterly prohibited. They destroy dignity and induce the people to despise medicine. Supplementary education to promote the practitioner's knowledge should be published by the medical association in a periodical with the latest scientific research and clinical experiences of physicians. Concluding, he says that there should soon be established the most rational medical system. The tendency of regarding medical practice as a commercial product he despises. He holds that medicine is a benevolent art and should be practiced in this principle.—Japan News Letter.

MISCELLANY

Under this department are ordinarily grouped: News; Medical Economics; Correspondence; Twenty-five Years Ago column; Department of Public Health; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings

American Medical Association, Atlantic City, New Jersey, June 10-14, 1935. Olin West, M. D., 535 North Dearborn Street, Chicago, Secretary.

American Association for the Study of Goiter, Salt Lake City, June 24-26, W. Blair Mosser, M. D., 133 Biddle Street, Kane, Pennsylvania, Secretary.

American Urological Association, San Francisco, June 24-28, 1935. William E. Stevens, M. D., 870 Market Street, San Francisco, Chairman, Committee on Arrangements.

Nevada State Medical Association, Elko, Nevada, October 25-26, 1935. Horace J. Brown, P. O. Box 698, Reno, Secretary.

Pacific Northwest Medical Association, Spokane, Washington, June 27-29. C. W. Countryman, M. D., 407 Riverside, Avenue, Spokane, Washington, Secretary.

Medical Broadcasts*

American Medical Association Health Talks.—The American Medical Association broadcasts on a western network of the Columbia Broadcasting System each Thursday afternoon on the Educational Forum from 4:30 to 4:45, Chicago daylight saving time (3:30 p. m. central standard time).

The American Medical Association broadcasts, under the title "Your Health," on a Blue network of the National Broadcasting Company each Tuesday afternoon from 4:00 to 4:15, Chicago daylight saving time (3 p. m. central standard time).

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San Francisco County Medical Society.—The radio broadcast program for the San Francisco County Medical Society for the month of June is as follows:

Tuesday, June 4—KJBS, 11:15 a. m., and KFRC, 1:15 p. m.
Tuesday, June 11—KJBS, 11:15 a. m., and KFRC, 1:15 p. m.
Tuesday, June 18—KJBS, 11:15 a. m., and KFRC, 1:15 p. m.
Tuesday, June 25—KJBS, 11:15 a. m., and KFRC, 1:15 p. m.

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Los Angeles County Medical Association.—The radio broadcast program for the Los Angeles County Medical Association for the month of June is as follows:

Saturday, June 1—KFI, 9 a. m. Subject: The New Frontier.
Saturday, June 1—KFAC, 10:15 a. m. Subject: Your Doctor and You.
Tuesday, June 4—KECA, 11:15 a. m. Subject: The New Frontier.
Saturday, June 8—KFI, 9 a. m. Subject: The New Frontier.
Saturday, June 8—KFAC, 10:15 a. m. Subject: Your Doctor and You.
Tuesday, June 11—KECA, 11:15 a. m. Subject: The New Frontier.
Saturday, June 15—KFI, 9 a. m. Subject: The New Frontier.
Saturday, June 15—KFAC, 10:15 a. m. Subject: Your Doctor and You.
Tuesday, June 18—KECA, 11:15 a. m. Subject: The New Frontier.
Saturday, June 22—KFI, 9 a. m. Subject: The New Frontier.
Saturday, June 22—KFAC, 10:15 a. m. Subject: Your Doctor and You.
Tuesday, June 25—KECA, 11:15 a. m. Subject: The New Frontier.
Saturday, June 28—KFI, 9 a. m. Subject: The New Frontier.
Saturday, June 28—KFAC, 10:15 a. m. Subject: Your Doctor and You.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

Stanley P. Black Memorial Lectures.—The 1935 lecture of this series was held in the Stanley P. Black Memorial Hall, 65 North Madison Avenue, Pasadena, on Wednesday, May 1, at 8:15 p. m.

The guest speaker was G. V. Anrep, M. D., F. C. D., F. R. S., professor of physiology, medical faculty of the Egyptian University, Cairo, Egypt, who spoke on the subject, "The Regulation of the Coronary Blood Flow."

Leslie Dana Gold Medal.—The Leslie Dana Gold Medal, awarded annually for outstanding achievements in the prevention of blindness and the conservation of vision, will be presented this year to Dr. William H. Wilder of Chicago, it is announced by Lewis H. Carris, managing director of the National Society for the Prevention of Blindness. Doctor Wilder was selected for this honor by the National Society in coöperation with the St. Louis Society for the Blind.

The medal, offered annually by a director of the St. Louis Society, is a prized mark of recognition of service for the conservation of vision. It will be presented to Doctor Wilder at ceremonies in St. Louis on May 18. The medal bears the inscription: "Wise Clinician, Devoted Teacher and Humanitarian."

Doctor Wilder is secretary-treasurer of the American Board of Ophthalmology; vice-president of the Illinois Society for the Prevention of Blindness; professor emeritus of ophthalmology at Rush Medical College, University of Chicago; and a past president of the American Academy of Ophthalmology and Otolaryngology.

The Leslie Dana Medal was awarded last year to Professor F. de Lapersonne of Paris, president of the International Association for Prevention of Blindness.

American Association for the Study of Goiter.—The tentative program for the 1935 meeting, to be held on June 24, 25, and 26, at Salt Lake City, Utah, includes papers as follows:

Etiology and Treatment of Recurrent Hyperthyroidism—Dr. Gordon S. Fahrni, Winnipeg, Canada.

Malignant Goiter—Statistical Survey of Sixty Cases, with Comparison of Geographical Types—Dr. Robertson Ward, San Francisco.

Some Problems in Thyroid Disease—Dr. Frank E. Rogers, Denver, Colorado.

Calcinosis Universalis—Dr. Edwin G. Ramsdell, White Plains, New York.

The Etiology of Hyperparathyroidism—Collaboration with Dr. L. P. Howell of the Clinic—Dr. Russell M. Wilder, Rochester, Minnesota.

Myxedema and Hypothyroidism—Dr. S. D. Conklin, Sayre, Pennsylvania.

Thyroidectomy for Psychosis of Hyperthyroidism—Dr. LeRoy Downing Long, Oklahoma City, Oklahoma.

Twenty Years' Experience in the Management of Goiter—Dr. E. C. Moore, Los Angeles.

Toxic Adenoma of the Thyroid with Associated Hypothyroidism—Dr. H. H. Searls, San Francisco.

Malignant Exophthalmus—Dr. George W. Swift, Seattle, Washington.

The Surgery of the Parathyroid Glands—Dr. Fred W. Rankin, Lexington, Kentucky.

Riedel's Struma—Dr. Frederick A. Coller, Ann Arbor, Michigan.

The Lingual Thyroid—Dr. M. L. Montgomery, San Francisco.

Quantitative Observations on the Effect of Iodin in Exophthalmic Goiter in Chicago—Dr. Willard O. Thompson, Chicago, Illinois.

A Clinical Analysis Plus Unusual Cases—Dr. Millard Rosenblatt, Portland, Oregon.

Tendency Toward the Medical Treatment of Exophthalmic Goiter—Dr. Arnold Minnig, Denver, Colorado.

Licensing in California of Foreign Graduates in Medicine.—From a letter we quote: "California Senate Bill 155 amends Section 10 of the Medical Practice Act, requiring graduates of foreign schools to serve a one-year internship in a hospital in the United States or take a senior year in an approved medical college in the United States. The measure passed the Senate and is on third reading file in the Assembly. It should be passed because of the fast developing influx of foreign medical graduates, whose credentials are practically impossible to satisfactorily verify, particularly Russian and German."

American Urological Association Meeting. — The coming meeting of the American Urological Association, which will be held in the Palace Hotel in San Francisco on June 26 to 28, will be attended by many of the prominent urologists of the United States, a number of eminent foreign guests, and practically every physician interested in urology in the western portion of the United States.

Dr. Luigi Caporale of Torino, Italy, will participate. He has been specially delegated to attend by Mussolini, who realizes the great importance of international contact and interchange of medical ideas. Dr. Aquilino Villanueva, Secretary General of the Department of Public Health of Mexico City and chief urologist of the Hospital General, and one of the outstanding urologists of our sister republic, will also attend. A number of prominent American urologists will converge toward San Francisco in June. Lowler and his associates will come from Cleveland, Ohio, and present interesting papers on the control of prostatic hypertrophy by the use of hormones which they have discovered and which promise to be an additional method of attack for the relief of prostatism. Russell S. Ferguson of New York will talk on the control of cancer of the genito-urinary tract. Bud Corbus of Chicago will talk on the Corbus-Ferry gonococcus filtrate which has proven to be a great adjunct in the treatment of gonorrhea. Tuberculosis of the genito-urinary tract will be discussed by T. Leon Howard of Denver, who has had wide experience in the treatment of urinary tuberculosis. David W. MacKenzie of Montreal, Canada, will relate the results obtained in making an experimental study of the relation of infections of the genital and lower urinary tract to those of the kidney. E. Granville Crabtree of Boston will present new ideas concerning the roentgenological diagnosis of urological and gynecological disease of the female bladder. An interesting paper will be that of Richard Chute, also of Boston, who will show the relationship between hyperthyroidism and the formation of kidney stones. Other urologists who will attend and who have assisted in making American urology are: Nathaniel P. Rathbun of Brooklyn, past president of the American Urological Association, Henry G. Bugbee of New York, C. R. O'Crowley of Newark, and Oswald Lowsley, a former Californian, and now director of the Brady Urological Institute of New York.

Professor Hugh Hampton Young, director of the Brady Urological Institute of Johns Hopkins University, will deliver the Ramón Guiterras lecture. Professor Young is the first American urologist who has been selected to deliver this lecture which heretofore has been given by eminent foreign urologists. He has selected for his topic: "The Abnormalities and Plastic Surgery of the Lower Genito-Urinary Tract."

It is well that the medical men of the West interested in urology should plan their vacations in order to attend the coming meeting of the American Urological Association to be held in San Francisco this summer. It will afford an opportunity to hear the most prominent urologists of the Western Hemisphere and to become acquainted with the latest developments and newest discoveries in the urological field. Information concerning the meeting may be obtained from Charles P. Mathé, M. D., Chairman, Publicity Committee, 450 Sutter Street, San Francisco.

California Cities Win Health Contest.—For the last six years the Chamber of Commerce of the United States, in coöperation with the American Public Health Association, has been conducting a nation-wide public health contest for cities of different sized populations. The winners for 1934 have just been selected.

The contest, open to cities anywhere in the country, is for the purpose of determining which cities of various populations are carrying on the most effective community public health programs, in an effort to prevent unnecessary and premature deaths and economic losses due to preventable illness.

In the larger cities, of 500,000 population and over, the first award goes to Baltimore, Maryland, and honorable mention to Buffalo, New York.

In Group II, cities of 250,000 to 500,000 population, Newark, N. J., attains the first award, and honorable mention goes to Minneapolis, Minn.; Toledo, Ohio; and Dallas, Texas.

In Group III, cities of 100,000 to 250,000 population, Honolulu, Hawaii, wins first place, and honorable mention goes to Hartford, Conn.; Grand Rapids, Mich.; Springfield, Mass.; Duluth, Minn.; Yonkers, N. Y.; Reading, Pa., and Utica, N. Y.

Group IV, cities of 50,000 to 100,000 population, *Pasadena*, receives the first award, and honorable mention goes to Kalamazoo, Mich.; Schenectady, N. Y.; Evanston, Ill.; Waterbury, Conn.; *Sacramento*; Binghamton, N. Y.; *San Jose*; New Rochelle, N. Y., and Greensboro, N. C.

Group V, cities of 20,000 to 50,000 population, the winner is Hackensack, N. J., and honorable mention goes to Watertown, N. Y.; Pittsfield, Mass.; Auburn, N. Y.; Greenwich, Conn., and *Santa Barbara*.

In Group VI, cities with a population under 20,000, *Palo Alto*, obtains the first prize, and honorable mention goes to Englewood, N. J.; Cliffside Park, N. J.; Hibbing, Minn., and Miami Beach, Fla.

Special awards to a small group of cities which were excluded from the contest proper for having twice won first place in their respective population groups and at the same time maintaining their high standards of health achievements in 1934, were granted to (arranged alphabetically) Brookline, Mass.; Detroit, Mich.; Milwaukee, Wis.; New Haven, Conn., and Syracuse, N. Y.

With 214 cities entered, representing forty-four states, the Islands of Hawaii, and Alaska, there were forty awards given. These awards, including both winning and honorable mention prizes of the contest itself and the special awards to cities which have twice previously won the contest, were distributed over fifteen states. New York State led the country with nine awards, followed by California with five. Four prizes each went to Connecticut and New Jersey; and Massachusetts, Michigan, and Minnesota received three each. One award each was given to Florida, Hawaii, Illinois, Maryland, North Carolina, Ohio, Pennsylvania, Texas, and Wisconsin.

Of the first-place winners, California received two; New Jersey two; the Islands of Hawaii one, and Maryland one. The fact that New York and California won so many awards is probably due not only to the fact that they both have splendid examples of good local health services, but also to the very active support and help of the State Department of Health in these states.

Cities are graded on such items as the safety and availability of water supplies, sewage disposal, supervision and protection of milk supply, the extent to which children are protected against communicable diseases as diphtheria and smallpox, how many expectant mothers are obtaining proper prenatal care, how many babies are being kept well by adequate medical supervision, and to what extent are physicians and dentists in private practice carrying on preventive medical and health promotion services.

It is very gratifying to find that the death rates are declining more rapidly in the cities participating in the contest than in the country as a whole. This may well reflect the greater progress made in all health matters in these cities.

Accidental Deaths in California.—The California State Department of Public Health has released the statistics on accidental deaths in California for the year 1934, showing as follows: Total occupational deaths, 414; public deaths (not motor vehicle), 1,025; accidental deaths in the home, 1,292; accidental deaths charged to motor vehicles, 2,798; type unknown, 37.

American Public Health Association.—Dr. Eugene L. Bishop, president of the American Public Health Association, announces the appointment of Reginald M. Atwater, M. D. Dr. P. H., as executive secretary of the association.

The American Public Health Association is the technical society of the professional public health workers of North America. Its sixty-fourth annual meeting will be held in Milwaukee, October 7 to 10.

Anesthesia Control Subject of Meeting.—Ways and means of controlling the use of divinyl oxid as a general anesthetic in order to prevent its use by unauthorized or incompetent persons, were discussed at a recent meeting at the University of California Medical School, attended by Dr. Randolph T. Major, New York City; Dr. A. E. Guedel, Los Angeles; Dr. Dorothy Wood, University of California Hospital; and Dr. C. D. Leake, professor of pharmacology of the University of California Medical School.

The agent of divinyl oxid was developed at the Medical School and recently has come into wide use, both in the United States and abroad. It is one of the most powerful anesthetics known and, if properly used, induces quicker recovery and less discomfort than other agents. It was given its first surgical use at the University of California Hospital, with Doctor Wood as anesthetist, when, according to Doctor Leake, "its practical advantages were clearly evident."

Babies Are Safe in San Francisco.—The Department of Public Health of the City and County of San Francisco on May 13 issued a bulletin as follows:

The following are comparative health statistics for thirteen major cities in the United States. Particular attention is called to the remarkable record in San Francisco as to the infant death rate, which justifies the slogan consistently used by this Department of Health, namely, "Babies are safe in San Francisco."

Attention is also called to the irreducible minimum rate with reference to diphtheria. Needless to say, I am very proud of this showing.

J. C. GEIGER, M. D., *Director.*

*Comparative Health Statistics**
(Cities of over 500,000 Population)

City	Death Rate	Infant Death Rate	Tuberculosis (All forms) Death Rate	Diphtheria Death Rate
San Francisco	11.65	33.0	66.0	0.15
Los Angeles	11.71	52.71	81.45	3.2
New York	10.15	52.22	59.14	1.38
Chicago	10.4	47.7	55.6	1.2
Philadelphia	12.47	53.78	70.32	1.09
Detroit	8.8	50.7	61.9	0.7
Cleveland	10.7	44.8	69.1	3.0
St. Louis	13.99	58.0	59.95	4.51
Baltimore	13.3	65.3	77.9	0.8
Boston	14.24	54.88	66.0	1.1
Pittsburgh	11.9	54.9	51.6	5.4
Milwaukee	8.1	44.0	30.0	1.5
Buffalo	11.6	56.3	60.1	1.0

* The above tabulation is copied from the annual report for the City of Milwaukee, for 1934.

The American Association of the History of Medicine.—The eleventh annual meeting of the American Association of the History of Medicine was held in Atlantic City, New Jersey, on May 6, 1935. The program was dedicated to the memory of Dr. Joseph P. O'Dwyer, who was one of the world's greatest medical benefactors to sick children. Fifty years ago he demonstrated to a skeptical medical profession his improved laryngeal tubes and published his first article on this new and, as it proved, life-saving method for treating severe forms of laryngeal diphtheria.

Through the courtesy of Professor James W. Crane of the University of Western Ontario at London, Ontario, and Professor Jabez H. Elliott of Toronto, Ontario, there was exhibited both the bag in which Doctor O'Dwyer carried his intubation set and a complete assortment of models of the tubes by which he saved, and taught other physicians to save the lives of hundreds of children, many of which would, without the aid of the intubation tube, have died a wretched death of slow strangulation.

It was eminently fitting that the address concerning Doctor O'Dwyer and his work should have been made by Professor Chevalier Jackson who, following Doctor O'Dwyer originated and popularized in the medical profession another life saving and health promoting method of direct visual diagnosis and equally direct treatment, namely, bronchoscopy and esophagoscopy. Dr. William S. Middleton of Madison, Wisconsin, was elected president and Dr. Walter C. Alvarez of Rochester, Minnesota, vice-president. For additional information write to the secretary, Dr. E. J. G. Beardsley, 1919 Spruce Street, Philadelphia.

Tropical Disease (Onchocercosis) Moves Northward.—A much-feared tropical disease, widely disseminated throughout portions of Africa, has now been encountered in the highlands of Guatemala and southern Mexico. A definite northward trend of this disease has compelled far-reaching defense measures to prevent it from invading the United States. The disease is known as onchocerosis, a parasitic malady which, in its advanced stage, may cause blindness and other serious complications. Although there are no known cases in California, the buffalo gnat and related simuliid insects of the high Sierra and other elevations in the State, are known to be potential carriers of the disease.

The stricken black slaves from the African forests, with their nodule-covered heads and bodies, probably introduced this tenacious African disease into the New World. While the disease is not necessarily fatal and may be cured or checked by surgery in the lighter cases, it can cause blindness, delirium, convulsions and other complaints. The problem of control is greatly aggravated by the fact that the insect carriers hatch in swiftly running streams at high altitudes.

The Hooper Foundation for Medical Research of the University of California and the Pacific Institute of Tropical Medicine, within the Foundation, are closely watching the creeping northward course of this disease, and it is being as closely observed by other medical centers throughout the United States. The movement of Mexicans across the border, particularly those from the states of Chiapas, Oaxaca and Guerrero where the disease is now established, is being given particular attention.

A recent bulletin on onchocercosis, prepared by Dr. Herbert G. Johnstone and Dr. Albert E. Larsen of the Pacific Institute of Tropical Medicine in the University of California, details the history of this disease in North America and draws the following conclusion:

"The numerous Mexican immigrants in the United States provide an opportunity for the presence of a carrier of onchocerca caecutiens. This may lead subsequently to the contamination of our own simuliid species. If this occurs, a case of the disease is sure to make its appearance sooner or later, and once present it is difficult to eradicate."

Exhibit of Rare Medical Books at the University of California Medical School Library.—The University of California Medical School Library announces an exhibition of rare books recently presented to the Medical School by Mrs. Myrtle Crummer Ingram, in memory of her late husband, Dr. LeRoy Crummer. Among the books shown are the 1651 edition of Harvey's work on generation; a Latin edition of the great Renaissance work on obstetrics, "Rösslin's "de Partu Hominis"; Phrysius' "Spiegl der Artzny"; the 1628 edition of Aselli's "De Lactibus," and the famous poem by Alexander Pope, "An Epistle to Dr. Arbuthnot."

Bovine Tuberculosis.—Kansas, on May 1, was officially recognized by the United States Department of Agriculture as the nineteenth state practically free of bovine tuberculosis. The state was thus established as a modified accredited area, where tuberculosis among cattle has been reduced to less than one-half of one per cent. The other states are North Carolina, Maine, Michigan, Indiana, Wisconsin, Ohio, Idaho, North Dakota, Nevada, New Hampshire, Utah, Kentucky, West Virginia, Washington, Illinois, Oregon, Virginia, and Minnesota.

The testing of cattle for tuberculosis has been speeded up in Kansas during recent months through the use of emergency funds provided by the Jones-Connally Act.

The campaign to eradicate bovine tuberculosis is progressing rapidly in other states and during March 2,690,074 cattle in approximately 250,000 herds were tested—more than in any previous month in the history of the work.

American College of Surgeons — Clinical Congress and Annual Session at San Francisco. — For the twenty-fifth annual clinical congress, Monday, October 28 to Friday, November 1, the surgeons of San Francisco and Oakland have organized under the leadership of a representative committee, with Dr. Howard C. Naffziger as chairman, and are preparing a clinical program that will adequately present the surgical activities of that great Pacific Coast medical center.

The congress will open Monday morning at ten o'clock, with the annual hospital conference at the Fairmont Hotel. Clinics at the hospitals are scheduled for Monday afternoon at two o'clock, and will be continued during the following four days both morning and afternoon. A comprehensive and varied program of operative clinics and demonstrations, representing all departments of surgery, is being prepared. This will include a special series of clinics in surgery of the eye, ear, nose, and throat. The committee is also preparing programs for four morning sessions, at which distinguished ophthalmologists and otolaryngologists will present and discuss subjects of clinical interest.

Programs are being arranged for five evening meetings, at which eminent surgeons of the United States and Canada and a number of distinguished visitors from abroad will present and discuss papers dealing with surgical subjects of present-day importance. Plans are being made also for conferences on cancer, fractures, and industrial medicine and traumatic surgery. The president-elect, Dr. Donald C. Balfour, of Rochester, Minnesota, will be inaugurated at the presidential meeting on Monday evening. At the annual convocation of the College on Friday evening, when the 1935 class of candidates for Fellowship will be received, the Fellowship address will be given by Dr. Robert Gordon Sproul, president of the University of California.

Headquarters will be established at the Fairmont and Mark Hopkins hotels, the registration and information bureau, scientific and technical exhibitions, executive offices, etc., being located at the former. Ample first-class accommodations are available at nearby hotels. The railroads have authorized low round-trip rates from all sections of the country.

Attendance will be limited to a number that can be readily accommodated at the clinics so that registration in advance is necessary.

"Differences of Opinion as to Policies."—A recent bulletin of the Committee on Economics of the Medical Society of the State of New York prints: With this brief explanation the Milbank Memorial Fund announced the termination of the services of John A. Kingsbury and others, and, likewise, clearly indicated a new understanding of the individual medical practitioner's social and economic problems.

This event marks a new trend in the application of philanthropic funds to the present day and future needs of the professions and the people. Guidance by medical opinion, founded upon practical experience in the economics of the provision of medical care to all classes and conditions of people, will bring greater and more beneficent accomplishments than have been attained in the past.

Medicine is deeply indebted to Mr. Louis J. Auerbacher, president of the Dryco Company and director of medical relations of the Borden Company. His recognition of an opportunity to serve the common interests of all, his intelligent understanding and cordial, effective coöperation has changed the direction of one powerful current of influence.

American Proctologic Society. — The 1935 meeting will be held at Atlantic City on Monday and Tuesday, June 10 and 11, with headquarters at the Marlborough-Blenheim.

The American Proctologic Society, organized in 1899 for the purpose of "investigating and disseminating knowledge relating to the rectum, anus, and colon," is a society with a definitely limited membership, divided into fellows, associates, honorary fellows, and honorary associates.

Regular and orthodox practitioners, members of the American Medical Association, and not affiliated with medical groups admitting those not members of the American Medical Association, are cordially invited to attend the thirty-sixth annual meeting in Atlantic City, Monday and Tuesday, June 10 and 11—the week of the American Medical Association meeting.

Physicians fulfilling the above requirements who are especially interested in proctology are eligible to submit applications for associate membership after attending at least one meeting of the society and one meeting of the American Medical Association Section.

For additional information, address the secretary, Frank G. Runyeon, M. D., 1361 Perkiomen Avenue, Reading, Pennsylvania.

Medical Library Association. — This organization, founded in 1898 and incorporated in 1934, has its headquarters at 25 Shattuck Street, Boston, Massachusetts. Its thirty-seventh annual meeting of the Medical Library Association will be held in Rochester, New York, June 17 to 19. Sessions will be held at the Rochester Academy of Medicine and the University of Rochester Medical School.

The program includes addresses, round-table discussions and demonstrations on library procedure, medical history and medical literature.

The association is being represented by two delegates at the Congress of the International Federation of Library Associations to be held in Madrid May 19 to 30. These delegates will return in time to report upon the congress at this meeting.

This association consists of about 175 of the medical libraries of this country and Canada, together with their librarians and a group of supporting members of physicians interested in the advancement of medical libraries.

The officers of the association are as follows: President, Charles Frankenberger, of Brooklyn, New York; Vice-President, Louise Ophüls, of San Francisco; Secretary, Frances U. A. Whitman, Boston, Massachusetts; treasurer, Mary Louise Marshall of New Orleans, Louisiana; chairman of Executive Committee, Marjorie J. Darrach of Detroit, Michigan.

All interested in the development of medical libraries are invited to attend.

The American Neisserian Medical Society.—All who are interested are cordially invited to attend the annual meeting of the American Neisserian Medical Society to be held on June 11, 1935, at the Claridge Hotel, Atlantic City, New Jersey.

As the Survey Associates, Inc. (Publishers of the Survey Graphic Magazine), See Health Insurance in California.—The California Medical Association is the first important medical group in this country—and probably the first in the world—to offer full aid and coöperation in establishing a compulsory health insurance system, according to Mary Ross, staff expert on medical economics, writing in the May issue of *Survey Graphic Magazine* (New York). "Whatever this spring's legislative action at Sacramento, the stand of the doctors marks economic and social tides which cannot long be held back," says Miss Ross. "The economic barrier between people who need medical care and doctors who need income runs like a Chinese wall through all parts of our country. . . . The partnership of sickness and poverty is nothing peculiar to California. Surveys in a widely separated group of cities showed what the California SERA study strikingly confirmed: disabling sickness is far more common among the poorer than among the better-to-do." Miss Ross says that the action of the doctors expresses "the views of the less vocal doctors who have not entered into controversies on medical policies and of many 'little men' of the profession—country doctors, men with offices above drug stores, men from hard-hit industrial and agricultural counties and middle-class city neighborhoods—who had reason to know what medical costs mean to their patients and themselves."

Aside from the fact that California had a few years ago more physicians in proportion to population than any known area in the world, thus giving rise to competition among them, Miss Ross believes that the state's eighty years of experience with various forms of organized medical service have helped to point the issue. "Probably no health insurance law has ever come into being with the benefit of as wide knowledge and basic agreement as exists in California at the present time," says Miss Ross. "California has the chance to establish a model for the whole American continent."

CORRESPONDENCE

Concerning Antivivisection Bill (A. B. 2401).

May 1, 1935.

To the Editor:—For your information I am enclosing a copy of a letter sent to assemblymen and the senator from this district. Sincerely,

J. C. GEIGER, M. D.,
Director of Public Health.

* * *

Member, California Legislature, Sacramento, California:

May I offer a protest to Assembly Bill 2401, the so-called Humane Pound Bill. This bill is one against animal experimentation.

There are two universities and one research institution that may be involved in animal experimentation for scientific purposes in San Francisco, namely, the Medical School of the University of California, Stanford University School of Medicine, and the Hooper Foundation for Medical Research of the University of California.

It is the writer's opinion that to pass this bill would grant, or serve as an excuse, to many persons, either officially or otherwise, to act as inspectors and annoy legitimate research workers by requesting, and perhaps demanding, search for certain dogs or insisting that the dogs are in the institutions. Moreover, I consider this bill entirely anti-medical, and as an individual and for the Department of Public Health, vehemently protest it. Furthermore, if anything anti-medical inimical to animal experimentation upon which much of our modern public health depends comes from a committee officially dedicated to health it would appear to be a travesty on health.

May I point out to you that animal experimentation as a means of promoting human and animal welfare has recently received the sanction of two tribunals of great importance, one in the United States and the other in England. Both decisions tend to brighten the outlook for the protection of medical science against the perpetual warfare that threatens it through bequests for the support in perpetuity of organizations opposed to experiments on animals.

In the American case (Pennsylvania Company for Insurance on Lives and Granting of Annuities, executor of the Estate of A. Sidney Logan, deceased, petitioner vs. Commissioner of Internal Revenue, respondent, 25 B. T. A.), the United States Board of Tax Appeals held that a bequest to a society organized for the "total abolition of all vivisectional experiments on animals and other experiments of a painful nature" was not a bequest to a corporation organized and operated exclusively for the prevention of cruelty to animals, and that, therefore, the amount of such a bequest could not be deducted from the principal of an estate in computing the federal estate tax. The decision of the Court of Appeals in the English case (in re Grove-Grady: In re Plowden vs. Lawrence, 98 L. J., Ch. 261 (1920), 1 Ch. 557, the Law Journal 71:329 (May 9), 1931), raised the question whether, "in the light of later knowledge in regard to the benefits accruing to mankind for vivisection," bequests designed to hinder and prevent vivisection would today be regarded as charitable bequests. On appeal, the House of Lords forbade the use for antivivisection propaganda of any part of the legacy concerning which the question was raised. The English decision is of only persuasive influence in the United States, but the changing view suggested by it with respect to bequests to create trusts to carry on activities against animal experimentation is of vital importance. Unless such trusts can be shown to be charitable in character, they cannot be made to operate in perpetuity.

The decision of the United States Board of Tax Appeals is available. It is a remarkable statement of the value of experimentation, all the more cogent because of the dispassionate, non-medical, judicial source from which it emanated. The executor of the estate against whom the decision was rendered may appeal to the courts for relief, but a decision by an appellate court would almost certainly do nothing more than strengthen the defense of animal experimentation that the decision affords.

These cases should be read by all members of your committee. Certainly the weight of the evidence proves that animal experimentation is of benefit to mankind—and to animals, too, for that matter. If animal experimentation is for the benefit of mankind and of animals, bequests and laws to hinder or prevent such experimentation obviously cannot be for the benefit of mankind, and bequests to accomplish that end cannot be charitable bequests. It may be argued that such reasoning is begging the question: that it assumes that the benefits that have been and are being derived from animal experimentation are at best not sufficient to offset the alleged cruelty to such experimentation. The answer is that there is no cruelty associated with animal experimentation that is not within the reach of the ordinary laws for the prevention of cruelty to animals. The fact that prosecutions for cruelty in connection with animal experimentation are practically unheard of, despite the vigilance of antivivisectionists, is evidence of the absence of such cruelty. The trouble with the antivivisectionists' reasoning lies in the fact that they fail to distinguish between pain and cruelty and set up their own standards of cruelty, which are not the standards of the law nor the standards of the community.

Probably these two legal decisions represent the general trend of mature and cultured thought on the subject of animal experimentation, when uninfluenced by lurid appeals to the imagination and by appeals to self interest. Both decisions were based on the orderly presentation of legal evidence, not on such clamorous, virulent, emotional speech-making as commonly fill the air when animal experimentation is discussed before legislative committees.

Sincerely,

J. C. GEIGER, M. D., *Director.*

Concerning malpractice defense: correction of an error.

A CORRECTION

In the April, 1935, issue of CALIFORNIA AND WESTERN MEDICINE, page 334, there appears the printed reproduction of a letter from Dr. Horace F. Pierce to the secretary of the California Medical Association in which Doctor Pierce expresses appreciation for the services rendered in a case brought against him by one Romero by the Medical Defense Fund through W. M. Rains. This article appeared in the column headed "Correspondence," under the heading "Concerning malpractice defense rendered through the medical society of the State of California. A letter of appreciation."

Mr. W. M. Rains, who is therein referred to, is associated with Attorney W. I. Gilbert of Los Angeles, the regularly retained attorney in Los Angeles County and vicinity for the Medical Protective Company of Fort Wayne, and the successful defense of Doctor Pierce in this case was entirely in the hands of Mr. Gilbert and his associate, Mr. Rains.

TWENTY-FIVE YEARS AGO*

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. VIII, No. 6, June 1910

From Some Editorial Notes:

Notice.—The statement has been made by sundry persons who should know better, that the accounts of the Society have never been investigated. This is absolutely untrue. Every item of income or expense has been accounted for and examined by an expert accountant, beginning in May, 1905. The books are closed on the 31st of December of each year and turned over to an expert accountant, who is employed by the Council for that purpose. . . .

* * *

Medical Defense.—The most important action of the House of Delegates at the last meeting, Sacramento. April 20, 1910, was undoubtedly the establishment of medical defense on a permanent basis. The experience of other states and our own experience since last July have shown conclusively that all members may be defended in all suits for alleged malpractice for a comparatively small sum per annum. . . .

The plan adopted is very simple; there are but three requirements. First, you must be a member in good standing, dues paid in your county society, and you must have been in good standing at the time the alleged malpractice was committed. Second, the alleged malpractice must have occurred after you became a member of the society, or after the first day of July, 1909. Third, you must send to the secretary of the State Society, within forty-eight hours after you are served in any suit, a full, true and correct copy of the complaint together with a full statement of all the facts in the case. Is there anything difficult about any of these requirements? Pay your dues and keep them paid; notify the office of the Society promptly when you are sued or a suit is threatened. That is all there is to it. You will be put to no additional expense other than your dues. . . .

* * *

Easy Money.—Schemes innumerable there are for separating money from people. One is again reminded of the historic, if unflattering, remark of a New York police inspector when he raided the establishment of a notorious "sure-thing operator": "Preachers, doctors, and lawyers are the easiest suckers there are." . . .

James H. Parkinson, M.D., President, 1909-1910.—President Parkinson was born in Dalkey, County Dublin, Ireland, October 28, 1859, his father being Henry Parkinson, barrister-at-law, and his mother, Henrietta Flood. Both his grandfathers were physicians, and one granduncle, whose name is usually associated with Flood's interarticular ligament of the shoulder joint. He received his education at private schools, passing the entrance examination of the Royal College of Surgeons, Ireland, from Kingstown school. . . .

In 1887 Doctor Parkinson founded the *Sacramento*, later the *Occidental Medical Times*, and continued as its editor until it ceased publication in 1904. Doctor Parkinson was elected president of the State Society in April, 1909, and presided at the sessions at Sacramento, April, 1910.

* This column strives to mirror the work and aims of colleagues who bore the brunt of Association work some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

(Continued in Front Advertising Section, Page 14)

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA*

By CHARLES B. PINKHAM, M.D.
Secretary-Treasurer

News

"Following anti-foreign manifestations of five thousand French students in the Latin Quarter, the Chamber of Deputies is discussing a bill providing that naturalized foreigners cannot practice as doctors in France until ten years after their naturalization. However, those having done important military service in the French Army, and also students duly inscribed at the date the law is promulgated, may be exempted from this restriction." (Press dispatch, dated Paris, April 20, and printed in the San Francisco *Examiner*, April 21, 1935.)

"While members mimicked the barks of dogs, the Assembly yesterday refused to bring from the Public Health and Quarantine Committee a bill by Assemblyman Charles J. Wagner, designed to protect dogs from vivisection. Only seventeen members voted to bring the measure to the floor, with fifty-four opposing. . . . The committee tabled the bill when physicians and dentists urged its defeat on the ground it is an anti-vivisection measure in disguise. They argued an anti-vivisection act would prevent medical science from performing experiments necessary for the health of the human race." (Sacramento *Bee*, May 11, 1935.)

"Testimony of a bevy of pretty girls and a 'fashion show' which failed to have its première resulted in the conviction of F. J. Miller, self-styled doctor and radio artist on petty theft charges in Police Judge Chris B. Fox's court yesterday. He will be sentenced on Monday. According to police, Miller advertised for models to work in a 'fashion show' he was promoting. Seventy-five girls applied. Among them was Ann Pendleton. Miller, she said, offered her the job of 'show manager,' then he requested payment of a $20 bond. She paid the money. Marie Haug was offered a position of 'secretary,' with the proviso that a $50 bond be paid. Lorraine Colbert . . . said Miller demanded a $2.50 bond. Police declared Miller asked for similar payments from other applicants. . . . According to Los Angeles police, Miller served a 180-day jail term there for alleged violation of the State Medical Practice Act. They declared he exhibited papers to show that he was the highly publicized 'Brother Jack' of Aimee Semple McPherson's Angelus Temple radio station. Miller told Oakland police he was a doctor who was graduated from a Vienna University in 1912." (Oakland *Tribune*, April 26, 1935.) (Previous entries, July, 1933, advertising page 21.) According to the California State Division of Criminal Identification and Investigation, he is listed as "Dr. Frank J. Mills, alias Dr. Frank H. B. Miller; Franklin J. Miller, Frank Joseph Miller; Los Angeles, No. 30693-M-11; San Diego, No. 9949-A."

"Walter Beck, Pismo Beach masseur, was found not guilty of violating State medical laws when he was tried before a jury in Justice of Peace L. C. Routzahn's court at Arroyo Grande Thursday. . . ." (San Luis Obispo *Telegram*, April 19, 1935.)

"Dr. Charles O. Long, formerly a physician and surgeon in Calapatria, was arrested in Phoenix Sunday on a narcotic charge and is being held in jail there

* The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.

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